NO TAXPAYER FUNDING FOR ABORTION ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION
AND CIVIL JUSTICE

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

ON

H.R. 7

JANUARY 9, 2014

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CONTENTS

JANUARY 9, 2014

NO TAXPAYER FUNDING FOR ABORTION ACT

THURSDAY, JANUARY 9, 2014

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON THE CONSTITUTION
AND CIVIL JUSTICE

COMMITTEE ON THE JUDICIARY

Washington, DC.

The Subcommittee met, pursuant to call, at 10:05 a.m., in room 2141, Rayburn House Office Building, the Honorable Trent Franks (Chairman of the Subcommittee) presiding.

Present: Representatives Franks, Jordan, Chabot, Forbes, King, Gohmert, DeSantis, Smith, Nadler, Scott, Cohen, and Deutch.

Staff Present: (Majority) Paul Taylor, Subcommittee Chief Counsel; Tricia White, Clerk; (Minority) Heather Sawyer, Counsel; and Veronica Eligan, Professional Staff Member.

Mr. FRANKS. Committee will come to order. Want to welcome everyone to the Committee. Happy new year to you all. Welcome to the panelists, especially. And welcome back to my colleagues on both sides of this podium.

For well over 30 years, Congress has prevented the Federal funding of abortions through a patchwork of amendments that are added to various appropriations bills during each budget cycle prohibiting the Federal funding of abortions through their funded programs. Now is the time to pass one piece of legislation that puts Members on record supporting a prohibition on any Federal funding of abortion no matter where in the Federal system that funding might occur.

In poll after poll, the American people have overwhelmingly expressed their opposition to the Federal funding of abortions. H.R. 7 will ensure that American taxpayers are not involved in funding the destruction of innocent human life through abortion on demand. The No Taxpayer Funding for Abortion Act will establish a government-wide statutory prohibition on abortion funding by making permanent the various policies Congress has implemented on a case-by-case basis, including: The Hyde Amendment, which prohibits funding for elective abortion coverage through any program funded through the annual Labor, Health and Human Services Appropriations Act; the Helms Amendment, which prohibits funding for abortions as a method of family planning overseas; the Smith Amendment, which prohibits funding for elective abortion coverage for Federal employees; the Dornan Amendment, which prohibits the use of Congressionally appropriated funds for abortion in the

District of Columbia, and other policies such as the restrictions on elective abortion funding through the Peace Corps and Federal prisons.

Now, absolutely nothing in the Democrats' unpopular health care law prevents the Federal funding of abortions under the program it creates. Representatives Joe Pitts and former Representative Bart Stupak offered an amendment to the bill during the 111th Congress that would have prohibited government funding of abortion, had it been included in the final Health Care Reform Act. But that provision was stripped out of the Senate bill the President signed into law.

In the last-minute effort to work a face-saving political deal, the President said he would sign an executive order that claimed to limit Federal funding of abortions in some way. Then in an interview with the Chicago Tribune editorial board, former White House chief of staff Rahm Emanuel emphasized that the executive order signed by President Obama does not carry the force of law, and as such, was approved by the former House Speaker Nancy Pelosi and others who oppose a ban on taxpayer funding of abortion. Mr. Emanuel said, I quote, "Came up with the idea for an executive order to allow the Stupak Amendment not to exist in law."

There you have it. In the words of the President's chief of staff at the time, "the Obamacare law provides for the Federal taxpayer funding of abortions." Any Member who opposes that policy must support H.R. 7, which would at last put back into law the principle of the bipartisan Hyde Amendment and place a Federal Government-wide ban on the Federal funding of the destruction of innocent human life.

Now, I am fully aware of the controversy surrounding the underlying issues here. And throughout history, there has often been great intensity surrounding the debates over protecting the innocent lives of those who, through no fault of their own, find themselves obscured in the shadows of humanity. It encourages me greatly that in nearly all of those cases, the collective conscience was finally moved in favor of the victims. The same thing is beginning to happen in this debate related to innocent, unborn children. We are beginning to ask ourselves the real question: Does abortion take the life of a child? And we are beginning to finally able to realize as a human family that it does.

Ultrasound technology now demonstrates to all reasonable observers both the humanity of the victim and the inhumanity of what is being done to them. And we are beginning to realize as Americans that brutally taking the lives of the innocent unborn does not liberate anyone, and that 50 million dead children is enough. I look forward to hearing from the witnesses.

And I now recognize the Ranking Member of the Subcommittee, Mr. Nadler, for his opening statement.

[The bill, H.R. 7, follows:]

I

113TH CONGRESS
1ST SESSION

H. R. 7

To prohibit taxpayer funded abortions.

IN THE HOUSE OF REPRESENTATIVES

MAY 14, 2013

Mr. SMITH of New Jersey (for himself, Mr. LIPINSKI, Mr. PITTS, Mr. FLEMING, Mrs. ROBY, Mrs. BLACKBURN, Mr. JONES, Mr. BUCHANAN, Mr. FRANKS of Arizona, Mr. ROGERS of Alabama, Mr. FLORES, Mr. FLEISCHMANN, Mr. BOUSTANY, Mr. DUNCAN of South Carolina, Mr. FINCHER, Mr. CARTER, Mr. WESTMORELAND, Mr. GARRETT, Mr. PEARCE, Mr. ROE of Tennessee, Mr. NEUGEBAUER, Mr. POE of Texas, Mr. GOODLATTE, Mr. BENTIVOLIO, Mr. HARPER, Mr. SCHWEIKERT, Mr. WILSON of South Carolina, Mr. SCALISE, Mr. WOODALL, Mr. STUTZMAN, Mr. HUIZENGA of Michigan, Mr. WENSTRUP, Mrs. BACHMANN, Mr. AMASH, Mr. SHIMKUS, Mr. LAMALFA, Mr. WALBERG, Mr. BRADY of Texas, Mrs. BLACK, Mr. HUELSKAMP, Mr. CASSIDY, Mr. GOWDY, Mr. MEADOWS, Mr. FORTENBERRY, Mr. WOLF, Mr. BRIDENSTINE, Mr. SALMON, Mr. KING of Iowa, Mr. GINGREY of Georgia, Mr. HOLDING, Mrs. ELLMERS, Mr. LONG, Mr. SESSIONS, Mr. MARINO, Ms. ROS-LEHTINEN, Mr. CONAWAY, Mr. POMPEO, Mr. LAMBORN, Mr. KELLY of Pennsylvania, Mr. JOHNSON of Ohio, Mr. JORDAN, Mr. GUTHRIE, Ms. FOXX, Mr. HULTGREN, Mr. MESSER, Mr. ROYCE, Mr. BROUN of Georgia, Mr. GIBBS, Mr. THORNBERRY, Mr. ADERHOLT, Mr. RAHALL, Mr. ROGERS of Michigan, Mr. MULVANEY, Mrs. HARTZLER, Mrs. WAGNER, Mr. ALEXANDER, Mr. LANKFORD, Mr. HARRIS, Mrs. WALORSKI, Mr. OLSON, Mr. ROTHFUS, Mr. BARTON, Mr. DUFFY, Mr. SMITH of Nebraska, Mr. NUGENT, Mr. BURGESS, Mr. WOMACK, Mr. RODNEY DAVIS of Illinois, Mr. BACHUS, Mr. KLINE, Mr. BENISHEK, Mr. SOUTHERLAND, Mr. MILLER of Florida, Mr. STEWART, Mr. MCKINLEY, and Mr. YODER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on the Judiciary and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To prohibit taxpayer funded abortions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "No Taxpayer Funding for Abortion Act".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—PROHIBITING FEDERALLY FUNDED ABORTIONS

SEC. 101. PROHIBITING TAXPAYER FUNDED ABORTIONS.

Title 1, United States Code is amended by adding at the end the following new chapter:

"CHAPTER 4—PROHIBITING TAXPAYER FUNDED ABORTIONS

"§ 301. Prohibition on funding for abortions

"No funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal law, shall be expended for any abortion.

"§ 302. Prohibition on funding for health benefits plans that cover abortion

"None of the funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal law, shall be expended for health benefits coverage that includes coverage of abortion.

"§ 303. Limitation on Federal facilities and employees

"No health care service furnished—

"(1) by or in a health care facility owned or operated by the Federal Government; or

"(2) by any physician or other individual employed by the Federal Government to provide health care services within the scope of the physician's or individual's employment,

may include abortion.

"§ 304. Construction relating to separate coverage

"Nothing in this chapter shall be construed as prohibiting any individual, entity, or State or locality from purchasing separate abortion coverage or health benefits coverage that includes abortion so long as such coverage is paid for entirely using only funds not authorized or appropriated by Federal law and such coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"§ 305. Construction relating to the use of non-Federal funds for health coverage

"Nothing in this chapter shall be construed as restricting the ability of any non-Federal health benefits coverage provider from offering abortion coverage, or the ability of a State or locality to contract separately with such a provider for such coverage, so long as only funds not authorized or appropriated by Federal law are used and such coverage shall not be purchased using matching funds required for a federally subsidized program, including a State's or locality's contribution of Medicaid matching funds.

"§ 306. Non-preemption of other Federal laws

"Nothing in this chapter shall repeal, amend, or have any effect on any other Federal law to the extent such law imposes any limitation on the use of funds for abortion

or for health benefits coverage that includes coverage of abortion, beyond the limitations set forth in this chapter.

"§ 307. Construction relating to complications arising from abortion

"Nothing in this chapter shall be construed to apply to the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion. This rule of construction shall be applicable without regard to whether the abortion was performed in accord with Federal or State law, and without regard to whether funding for the abortion is permissible under section 308.

"§ 308. Treatment of abortions related to rape, incest, or preserving the life of the mother

"The limitations established in sections 301, 302, and 303 shall not apply to an abortion—

"(1) if the pregnancy is the result of an act of rape or incest; or

"(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

"§ 309. Application to District of Columbia

"In this chapter:

"(1) Any reference to funds appropriated by Federal law shall be treated as including any amounts within the budget of the District of Columbia that have been approved by Act of Congress pursuant to section 446 of the District of Columbia Home Rule Act (or any applicable successor Federal law).

"(2) The term 'Federal Government' includes the government of the District of Columbia.".

SEC. 102. AMENDMENT TO TABLE OF CHAPTERS.

The table of chapters for title 1, United States Code, is amended by adding at the end the following new item:

TITLE II—ELIMINATION OF CERTAIN TAX BENEFITS RELATING TO ABORTION

SEC. 201. DEDUCTION FOR MEDICAL EXPENSES NOT ALLOWED FOR ABORTIONS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(g) AMOUNTS PAID FOR ABORTION NOT TAKEN INTO ACCOUNT.—

"(1) IN GENERAL.—An amount paid during the taxable year for an abortion shall not be taken into account under subsection (a).

"(2) EXCEPTIONS.—Paragraph (1) shall not apply to—

"(A) an abortion—

"(i) in the case of a pregnancy that is the result of an act of rape or incest, or

"(ii) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy, and

"(B) the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 202. DISALLOWANCE OF REFUNDABLE CREDIT FOR COVERAGE UNDER QUALIFIED HEALTH PLAN WHICH PROVIDES COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subparagraph (A) of section 36B(c)(3) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: "or any health plan that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2))".

(b) OPTION TO PURCHASE OR OFFER SEPARATE COVERAGE OR PLAN.—Paragraph (3) of section 36B(c) of such Code is amended by adding at the end the following new subparagraph:

"(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

"(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

"(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).".

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 203. DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(1) by striking "Any term" and inserting the following:

"(1) IN GENERAL.—Any term", and

(2) by adding at the end the following new paragraph:

"(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The terms 'qualified health plan' and 'health insurance coverage' shall not include any health plan or benefit that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2)).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 204. DISTRIBUTIONS FOR ABORTION EXPENSES FROM CERTAIN ACCOUNTS AND ARRANGEMENTS INCLUDED IN GROSS INCOME.

(a) FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsections (k) and (l) as subsections (l) and (m), respectively, and by inserting after subsection (j) the following new subsection:

"(k) ABORTION REIMBURSEMENT FROM FLEXIBLE SPENDING ARRANGEMENT INCLUDED IN GROSS INCOME.—Notwithstanding section 105(b), gross income shall include any reimbursement for expenses incurred for an abortion (other than any abortion or treatment described in section 213(g)(2)) from a health flexible spend-

ing arrangement provided under a cafeteria plan. Such reimbursement shall not fail to be a qualified benefit for purposes of this section merely as a result of such inclusion in gross income.".

(b) ARCHER MSAS.—Paragraph (1) of section 220(f) of such Code is amended by inserting before the period at the end the following: ", except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such holder".

(c) HSAS.—Paragraph (1) of section 223(f) of such Code is amended by inserting before the period at the end the following: ", except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such beneficiary".

(d) EFFECTIVE DATES.—

(1) FSA REIMBURSEMENTS.—The amendment made by subsection (a) shall apply to expenses incurred with respect to taxable years beginning after the date of the enactment of this Act.

(2) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsection (b) and (c) shall apply to amounts paid with respect to

taxable years beginning after the date of the enactment of this Act.

○

Mr. NADLER. Thank you, Mr. Chairman. Today's hearing concerns what may be the most difficult and divisive issue we will have the opportunity to consider: A woman's right to make decisions about her own body. The right of a woman to decide whether to become pregnant and whether to continue or terminate her pregnancy is protected by the Constitution. Whether or not you think that is a good idea or a fair reading of the Constitution, it remains the law of the land. The Supreme Court has also determined that neither Congress nor a State may place an undue burden on that right.

Now comes H.R. 7, the "No Taxpayer Funding for Abortion Act," which is misleading and misnamed because the bill seeks to burden all women's health care choices in a variety of ways that have in nothing to do with Federal funds. Contrary to the assertions of its supporters, H.R. 7 is not the mere codification of existing law. This bill seeks to extend current funding restrictions in the Hyde Amendment that are limited in time and scope and to apply them to all Federal laws without any effort to determine how such a sweeping and permanent expansion would impact American women and their families.

If this were all, that would still be enough reason to oppose it. But H.R. 7 actually goes much further. This bill, for the first time ever, denies tax deductions and credits for women who use their own money to pay for an abortion or to purchase insurance that covers abortion, and in so doing, increases taxes for women and families with respect to one of the most personal, private decisions that they may face. So in effect, it imposes a tax increase on women who choose to use their own money for abortions, under certain circumstances. In particular,H.R. 7 denies the itemized tax deduction that otherwise is available for medical expenses if the expense is an abortion and treats as taxable income any distribution from a flexible spending account or health savings account that is used to pay for abortion expenses.

H.R. 7 denies small employers the ability to use tax credits to provide health coverage if that coverage includes abortion. The bill also denies income-eligible women the use of premium tax credits available under the Affordable Care Act if selected insurance coverage includes abortion. In first opposing and then voting to repeal the Affordable Care Act—not once, not twice, but I think we are up to 47 times now—my Republican colleagues have complained that government should not meddle in the private insurance market or in private health care choices. But this legislation obviously is designed to do just that.

It seems that many Republicans believe in freedom, provided no one uses that freedom in a way that they do not approve of. That is a strange understanding of freedom. Even more stunning, this bill increases taxes on families, businesses, and the self-employed if they spend their own money—let me repeat that, their own money, not Federal money—on abortion coverage or services. As we know, the power to tax is the power to destroy. And here the taxing power is being used to destroy the right of every woman to make private health care decisions free from government interference. This tax increase is being championed by Republicans, almost all

of whom have taken a pledge not to raise taxes on individuals or businesses, except here.

I am equally surprised to find out that my Republican colleagues think that a tax exemption or a tax credit is a form of government funding. Should we now consider every tax exemption or credit as a form of government funding for the recipient? I am sure there will be many businesses, charities, and religious denominations that will be alarmed to discover this.

I also join many other Americans in being absolutely horrified that the majority of this Committee seems to not know what rape is. When this bill was introduced in the last Congress, its sponsors sought to limit the Hyde Amendment rape exception to instances of "forcible" rape. Many in Congress and across America were outraged. According to the bill's champions, date rape drugs, and sex with minors were not really rape.

In the face of public outcry, the majority removed the term "forcible" from the bill before this Committee marked it up in the last Congress. But let no one misunderstand or be fooled by that change. My colleagues still seek to narrow the rape exception, as they made clear in the Committee report accompanying H.R. 3 in the last Congress, where they explained, "Reverting to the original Hyde Amendment language should not change longstanding policy. H.R. 3 with the Hyde Amendment language would still appropriately not allow the Federal Government to subsidize abortions in cases of statutory rape. The Hyde Amendment has not been construed to permit Federal funding of abortion based solely on the youth of the mother, nor has the Federal funding of abortions in such cases ever been the practice."

The majority's assertion, as explained in a memo from the National Women's Law Center is false. In fact, a 1978 regulation clarified that funding is required for all cases of rape, whether statutory or forcible. Nothing in the language of the Hyde Amendment qualifies the term "rape," and Congress rejected a proposal to limit the amendments to cases of forcible rape. It rejected it then, but this Committee would seek to change it now.

I ask unanimous consent that the National Women's Law Center memo be entered into the record.

Mr. FRANKS. Without objection.

Mr. NADLER. Thank you.

[The information referred to follows:]

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

MEMORANDUM

TO: Interested Parties
FR: National Women's Law Center
RE: The House Judiciary Committee Report on HR 3 Reflects an Attempt to Narrow the Rape Exception Even Though the Statutory Term "Forcible" Was Removed and Misrepresents Longstanding Policy on the Rape Exception

In January, Representative Chris Smith introduced H.R. 3, a bill that punishes private health decisions by raising taxes on individuals and small businesses with insurance plans that include coverage of abortion and makes permanent the ban on federal funding for abortion, often known as the Hyde Amendment. H.R. 3, as introduced, modified the longstanding rape exception to the Hyde Amendment by adding the term "forcible" before the word rape, thereby excluding rape that results from non-consent, or when a woman just says no, and, depending on how broadly or narrowly the term is construed, rape accomplished through threats of non-physical harm; previous violence coercing a woman to have sex, such as a serial abuser who demands sex; rape committed against an individual under the influence of drugs or alcohol at the time of the rape; and statutory rape, among others. In response to public outcry over this attempt to narrow the rape exception, the term "forcible" was deleted from the bill's text.

However, despite the fact that the term "forcible" was dropped from the bill's text, proponents of the bill still intend the term "rape" to exclude victims who were not raped "forcibly." The House Judiciary Committee Report states that "reverting to the original Hyde Amendment language should not change longstanding policy." According to proponents of H.R. 3, the intent of the bill is to narrow the rape exception to apply only to victims of "forcible" rape, whether or not the "forcible" modifier is in the bill's text.

Moreover, the House Judiciary Committee Report misrepresents the "longstanding policy" it specifically cites. According to the Report, the Hyde Amendment language does "*not* allow the Federal Government to subsidize abortions in cases of statutory rape. The Hyde Amendment has not been construed to permit Federal funding of abortion based solely on the youth of the mother ..."[1] This is false. A 1978 regulation implementing the Hyde Amendment made clear that the term "rape" included statutory rape.[2] In addition, states include statutory rape in their interpretations of the "rape" exception.[3] Every state that cites to a specific part of its criminal code to identify which crime victims are entitled to Medicaid funding for pregnancy termination *specifically includes* victims of statutory rape.[4] And in the states that just use the term "rape" or "sexual assault" and do not include explicit statutory references in their State Medicaid manuals, statutes or administrative codes to define rape for Medicaid purposes, the terms can be interpreted as being coterminous with state criminal code, and "most states have statutory rape and other sex offense statutes which criminalize sexual activity with minors who fall within a specified age range or are under a specified age."[5]

In sum, though the proponents of H.R. 3 deleted the term "forcible" from the bill's text, the House Judiciary Committee Report restores the proponents' intended meaning: that only victims of "forcible" rape can be included in the bill's rape exception, thereby narrowing longstanding policy and excluding some of the most vulnerable victims from the abortion care they need.

[1] H.R. Rep. No. 112-38, at 28, *available at* http://democrats.rules.house.gov/112/text/112_hr3_rpt.pdf.

[2] A 1978 regulation implementing the Hyde Amendment included discussion in the Federal Register about whether statutory rape is included in the term "rape." In its response to Comments, the Department of Health, Education and Welfare addressed comments that "criticized the regulations for including statutory rape within the exception permitting Federal funding of abortions for victims of rape." The Department, in relevant part, responded:

> This interpretation was clearly mandated by section 101 … Nothing in these words limits such funding to victims of forced rape. In addition, Congress considered, and failed to enact, a proposal that would have expressly limited the availability of Federal funding of abortions to victims of "forced" rape …. Thus, the failure to use the word "forced" in section 101 when referring to rape is conclusive evidence that Congress intended funding to be available for victims of statutory, as well as forced, rape ….

See Federal Financial Participation in State Claims for Abortions, 43 Fed. Reg. 31,873 (July 21, 1978).

[3] The Health Care Financing Administration (HCFA) issued guidance to State Medicaid Directors, shortly after the rape and incest exceptions were restored to the Hyde Amendment in 1993, that "The definition of rape and incest should be determined in accordance with each State's own law" in the Medicaid program. Letter from Sally K. Richardson, Director, Medicaid Bureau, Dep't Health & Human Servs. to State Medicaid Director 2 (Dec. 28, 1993). As such, state interpretations of "rape" in laws and regulations implementing bans on public funding for abortion and in Medicaid provider manuals govern here.

[4] There are four states that refer to specific criminal statutes to define which rape victims are entitled to Medicaid funding for abortion. Each state includes those who are victims due to their age. Alaska's regulations state that medical assistance funding is available where pregnancy resulted from "a crime of sexual abuse of a minor under AS-11.41.434-11.41.440." Alaska Admin. Code tit. 7, § 47.290 (2010). Arkansas's Medicaid manual states that coverage is available "for victims of rape … defined under Ark. Code Ann. § 5-14-103." Memorandum from the Div. of Med. Servs., Ark. Dep't Human Servs. to Ark. Medicaid Provider 3 (Aug. 1, 2004). The Arkansas code referenced by the Medicaid manual defines rape as including sexual intercourse with another person who is less than 14 years of age. Ark. Code Ann. § 5-14-103 (2010). Florida's Medicaid manual states that Medicaid reimburses "When the pregnancy is the result of rape as defined in section 794.011, F.S." Fl. Medicaid, Agency for Health Care Admin., Hospital Services Coverage and Limitations Handbook 2-3 (June 2005). The Florida statute referenced by the manual includes penetration by a person 18 years of age or older of a person less than 12 years of age. Fla. Stat. § 794.011 (2011). Wyoming's statute provides funding when the pregnancy is the result of "sexual assault as defined by W.S. 6-2-301." Wyo. Stat. Ann. § 35-6-117 (2011). The statute defines sexual assault as including "sexual abuse of a minor" crimes. Wyo. Stat. Ann. § 6-2-301 (2010) ("'Sexual assault' means any act made criminal pursuant to W.S. 6-2-302 through 6-2-319"); Wyo. Stat. Ann. § 6-2-314 through 317 (degrees of "Sexual abuse of a minor.").

[5] Susan M. Kole, Statute Protecting Minors in a Specified Age Range from Rape or Other Sexual Activity as Applicable to Defendant Minor Within Protected Age Group, 18 A.L.R.5th 856 (1994).

Mr. NADLER. In their Committee report, my colleagues displayed their true intent with regard to the exception for rape, which is to remove Federal assistance to children and teenagers who are the victims of predators. They have not been as transparent about the overall intent behind this bill, but it is nonetheless clear: it is to end insurance coverage for medically indicated abortions for all women, whether or not they obtain their insurance on an exchange, and even if they use their own money to purchase the insurance.

My colleagues in the majority believe that if you like your insurance coverage you should get to keep it, unless it is for choices that they don't like. Then they have no qualms about taking your coverage away. That is the intended and likely result of this bill. Currently, the vast majority of insurance products cover abortion services. But as Professor Sara Rosenbaum of GWU's School of Public Health testified in the last Congress, insurance companies will respond to the tax penalties this bill imposes by dropping coverage for abortions from all of their plans. This will have a significant effect on all women, not just lower-income women, who have long felt the brunt of Federal restrictions on their health care choices.

My colleagues blithely assert that coverage will be available if in no other way through supplemental insurance policies. But, as Professor Wood, the witness invited by the minority, can explain, there is no evidence that such product lines are being developed. H.R. 7 is not codification of existing law, nor is it just another attempt to enact the approach taken in the Stupak-Pitts Amendment to the House-passed Affordable Care Act. H.R. 7 is a radical departure from current tax treatment of medical expenses and insurance coverage. And it is neither justifiable nor necessary to prevent Federal funding of abortion.

I yield back the balance of my time, and I look forward to hearing from our witnesses today.

Mr. FRANKS. I thank the gentleman. And now I yield to the Chairman of the Committee, Mr. Goodlatte from Virginia, for an opening statement.

Mr. GOODLATTE. Thank you, Mr. Chairman, for holding this hearing. However stark Americans' differences of opinion can be on the matter of abortion generally, there has been long bipartisan agreement that Federal taxpayer funds should not be used to destroy innocent life. The Hyde Amendment, named for its chief sponsor, former House Judiciary Committee Chairman Henry Hyde, has prohibited the Federal funding of abortion since 1976, when it passed a House and Senate that was composed overwhelmingly of Democratic Members. It has been renewed each appropriations cycle with few changes over the last 38 years, supported by Congresses controlled by both parties and presidents from both parties.

It is probably the most bipartisan, pro-life proposal sustained over a longer period of time than any other. As such, it warrants codification in the United States Code. H.R. 7, the No Taxpayer Funding for Abortion Act, would do just that by codifying the two core principles of the Hyde Amendment throughout the operations of the Federal Government, namely, a ban on Federal funding for abortions and a ban on the use of Federal funds for health benefits coverage that includes coverage of abortion.

During the time the Hyde Amendment has been in place, probably millions and millions of innocent children and their mothers have been spared the horrors of abortion. The Congressional Budget Office has estimated that the Hyde Amendment has led to as many as 675,000 fewer abortions each year. Let that sink in for a few precious moments. The policy we are discussing today has likely given America the gift of millions more children and consequently millions more mothers and millions more fathers, millions more lifetimes, and trillions more loving gestures and other human gifts in all their diverse forms. What a stunningly wondrous legacy.

Thank you, Chairman Franks, for convening this hearing and thanks also to representative Chris Smith for sponsoring this vital legislation. I look forward to hearing from our witnesses today. However, I wanted to say just one more thing, Mr. Chairman. The gentleman from New York made reference to it being a radical departure from insurance policies. But the real radical departure here is the fact that now we will have, for the first time, Federal subsidies of health insurance policies in America. So that is the radical departure that we are facing, and that is why legislation is needed to address the fact that this will be a major substantial breach in the Hyde Amendment, the policy of the United States of America since 1976.

And I thank you and yield back.

Mr. FRANKS. And I thank the gentleman.

Are there any other opening statements?

Then I would now yield to Mr. Chabot, the gentleman from Ohio, for an opening statement.

Mr. NADLER. Mr. Chairman.

Mr. FRANKS. When he finishes his opening statement, we will consider unanimous consent.

Mr. NADLER. I'm sorry.

Mr. CHABOT. Thank you, Mr. Chairman. And thank you for your leadership on this issue for many years now.

Protection of the most vulnerable among us, the unborn, is one of the most important and most solemn duties that we, I believe, as elected officials, undertake. Since Roe versus Wade was decided almost 41 years ago, this Subcommittee in particular has been the focal point in the effort to curb abortions nationally. Most notably, it was this Subcommittee that first considered and approved the Partial Birth Abortion Ban Act of 2003, which I had the honor to introduce, which later passed both Houses of Congress, was signed into the law by President Bush, and upheld as constitutional by the United States Supreme Court. But as thousands of Americans prepare to head to Washington in about 2 weeks for the annual March for Life in remembrance of the approximately 50 million American lives lost to abortions since Roe was decided back on January 22, 1973, much more remains to be done. It is appropriate then that this Subcommittee again take the lead on legislation that will further limit the number of abortions performed in this country, especially with taxpayer dollars.

The No Taxpayer Funding for Abortion Act introduced by our colleague, Chris Smith of New Jersey, would prevent any Federal funding of abortion, whether channeled through insurance plans or

paid directly to abortion providers. The bill reaches back through history and seeks to make the Hyde Amendment, as has been mentioned a number of times already, and the Hyde/Weldon Conscience Protection clause and several other pro-life amendments permanent under Federal law. I would note that this bill is a legislative effort to actually implement Executive Order 13535 that President Obama issued back on March 24 of 2010. And that order stated, in part, "It is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services, consistent with the longstanding Federal statutory restriction that is commonly known as the Hyde Amendment."

Mr. Chairman, the No Taxpayer Funding for Abortion Act provides that enforcement mechanism and it has overwhelming public support. 2011 CNN poll found 61 percent of the respondents opposed public funding for abortion. And a 2010 Quinnipiac poll showed 67 percent of the respondents opposed Federal funding of abortion.

For these reasons, I would urge my colleagues to support this legislation. I thank you for holding this hearing today. Yield back.

Mr. FRANKS. And I thank the gentleman.

And I understand—go ahead.

Mr. NADLER. Mr. Chairman, may I be recognized for a unanimous consent request?

Mr. FRANKS. Without objection.

Mr. NADLER. Thank you, Mr. Chairman. This Subcommittee received a request from the delegate from the District of Columbia, Eleanor Holmes Norton, to be allowed to testify on this bill. I understand that she has been told that her request would not be accommodated. I ask unanimous consent that our colleague be given 5 minutes to address the Subcommittee on the matter that uniquely affects her constituents and only her constituents. That has been the common practice in the House.

Mr. FRANKS. I would have to have raise objection.

Mr. NADLER. I regret that the Chairman objects. I would hope that he would reconsider what is normally a fairly pedestrian request. This bill contains a provision that singles out the District of Columbia for additional restrictions on how it may spend its own local tax funds, not Federal funds. This is the equivalent of barring a State from making its own choices about how it wants to spend its own State funds. No Member would tolerate Congress telling their State or their town how to spend their own tax dollars, yet this bill would do just that to the citizens of our Nation's capital.

The exclusion of Delegate Norton, who is relegated to sitting in the audience today—and I want to welcome her and apologize for the manner in which she is being treated—is yet another example of an abuse of power. As I have said in the past, never in more than 20 years as a Member of this body have I seen a colleague treated as contemptuously as our colleague from the District of Columbia is being treated today. The gentlewoman from the District of Columbia is a Member of this body, and the people she represents are taxpaying American citizens. And yet this Committee can't be bothered to take 5 minutes to hear our colleague, who will not even be permitted to vote on the bill. The District of Columbia is not a colony, it is part of the United States, and its people are

entitled to be treated with the same respect that we demand for the people we represent.

Now, I know that it will be said by the Chairman, because he has said it to me, and there is no secret, that while the Democrats get one witness and if we want Eleanor—or the delegate from the District of Columbia to be our witness—we are free to do that. That is true. But that gives us a Hobson's choice. Because Eleanor's testimony would be only about the specifics of how this affects her district in a way unique to that district. And that would leave us no witness on the basic, broad import of the bill. On the other hand, if we have a witness on the basic, broad import of the bill, we don't have the opportunity, or Eleanor doesn't have the opportunity, to present the specifics of her district.

It is a common courtesy. There is no rule in the House that prevents this. And again, I ask that this be reconsidered. And that the common practice that has normally been common practice in this House that when a matter specifically affects a Member's district, she or he is given the opportunity to testify, be implemented here.

Mr. FRANKS. I would join the gentleman in recognizing and welcoming Mrs. Norton, Ms. Norton to the audience today. And would remind the gentleman that it does indeed remain true that the minority was entirely free to invite Ms. Norton as their witness. In fact, I extended that invitation personally both to the Chairman and to the Subcommittee Chairman, Mr. Nadler. But they declined. Now, since the bill that is the subject of the hearing today only mentions the District of Columbia to make clear that funds appropriated by Congress for the District of Columbia shall be, of course, considered Federal funds, just like all other Federal funds, there was no reason for the majority to call Ms. Norton as a witness. Ms. Norton is, of course, welcome to submit any materials she would like for the hearing record, which will be made part of the record without objection.

Mr. NADLER. Mr. Chairman. Mr. Chairman. With respect—what you just said is not completely accurate. This bill applies in a way that it applies nowhere else, to funds raised locally, by local tax funds in the District of Columbia. It does not apply to local tax funds raised in New Jersey, by the State of New Jersey, or anywhere else. Now, it does that by sleight of hand. It says, "The term 'Federal government' includes the government of the District of Columbia,' for the purposes of this bill. For most purposes, the term 'Federal Government' never includes the District of Columbia." So this bill has the unique effect of—for the District of Columbia only—telling them how they may use local funds raised by local sales taxes or income taxes or property tax in a way that is not done anywhere else. And, therefore, it is a unique application. And the common courtesy of the House demands that Ms. Norton be able to testify—not as our one witness but as a specific witness with respect to the application to her district. A courtesy that I have seen granted many, many times in this House. And in this Committee, for that matter.

Mr. FRANKS. The gentleman's objection is duly noted. And would just remind the gentleman that the District of Columbia is the seat of this government, according to the Constitution, and not a State. And consequently we will proceed.

Mr. NADLER. Mr. Chairman.

Mr. FRANKS. Now let me introduce our witnesses.

Mr. NADLER. Mr. Chairman, Mr. Chairman, Mr. Chairman. Mr. Chairman, you stated to me that the rules of the House are the rules of the Committee do not permit the seating of Ms. Norton as a witness other than our one witness. Could you please point out to me the rules of the House, the rules of the Committee that so indicate?

Mr. GOODLATTE. Would the gentleman yield?

Mr. FRANKS. Yes.

Mr. NADLER. Would I yield?

Mr. GOODLATTE. Mr. Chairman, I appreciate the circumstances, and I, too, welcome Ms. Norton's presence here. But, last year, at the beginning of this Congress, I announced to the full Committee our policy regarding the participation of Members who are not a Member of the Judiciary Committee or its Subcommittees, and here is what I announced.

"I want to take the opportunity of this full Committee gathering to make Members aware of our new policy regarding participation in Subcommittee hearings. At the beginning of the Congress, I was asked whether Members who are not a Member of a Subcommittee would be allowed to participate in Subcommittee hearings. After giving it some thought, I have come up with what I think to be a reasonable solution that will allow our Members some level of participation without overly burdening the Subcommittees. A Member of the Judiciary Committee who is not a Member of a Subcommittee may attend a hearing and sit on the dais. That Member may also ask questions of the witnesses. But only if yielded time by an actual Member of the Subcommittee who is present at the hearing. I would ask that Members who intend to participate in this fashion let the majority staff know as far in advance of the hearing as possible so that we may prepare accordingly. It will remain the policy of the Committee that we do not allow Members to participate in our hearings if they are not Members of the Judiciary Committee." Thank you, Mr. Chairman.

Mr. NADLER. Would the gentleman yield?

Mr. FRANKS. Gentleman from New Jersey has the time. There is really no time. At this point, I think——

Mr. NADLER. Gentleman from New Jersey?

Mr. FRANKS. I'm sorry. Wherever you are from. New York.

Mr. GOODLATTE. You mentioned New Jersey a couple times in your statements.

Mr. FRANKS. I apologize to people in both the States.

Mr. NADLER. Mr. Chairman, I would like to point out that that policy statement, A, is not a rule, but, B, refers to participation as a Member of the Committee or Subcommittee in asking questions. It does not refer to testifying before the Committee. And again it has been the practice in the House that we afford the courtesy—we would have been well finished with this by now if you had done that, by the way—to a Member whose district is uniquely affected to testify. We have had panels of only Members. There is nothing that says you can't do this if you have the common courtesy to do it.

Mr. FRANKS. I would just suggest to you to remind the gentleman, the House rules provide for the participation in hearings only by Members of that Committee or Subcommittee. House Rule 11 states, "Each Committee shall apply the 5-minute rule during the questioning of witnesses in a hearing until such time as each Member of the Committee who so desires has had an opportunity to question each witness." Now I feel like I have——

Mr. NADLER. Mr. Chairman, again, that is questions, has nothing to do with testifying.

Mr. FRANKS. A UC is required in order to allow non-Judiciary Member to participate.

Mr. NADLER. No, I'm not talking about participating.

Mr. FRANKS. I have given the gentleman ample time to state his point and respectfully——

Mr. NADLER. You are misstating my point. I am not talking about participating, I am not talking about asking questions. I am talking about testifying. It is an entirely different matter.

Mr. GOODLATTE. Will the gentleman yield?

Mr. FRANKS. Please.

Mr. GOODLATTE. I want to reiterate the Committee's position, and not just in this Congress but in previous Congresses as well is that non-members of the Committee do not sit on the dais. That was the gentleman's subsequent request. His original request was that she be given 5 minutes to testify.

Mr. NADLER. That is my request.

Mr. GOODLATTE. That requires unanimous consent. That was rejected by the Chairman. And the Chairman made it very plain, and I will again, that she is very welcome to submit any materials that she would like to for the hearing record, which will be made part of the record without objection.

Mr. FRANKS. Thank you. And now I would like to introduce——

Mr. NADLER. Can I ask unanimous consent in view of the rudeness——

Mr. FRANKS. Gentleman is not recognized.

Mr. NADLER [CONTINUING]. Ask unanimous consent to——

Mr. FRANKS. Unanimous consent.

Mr. NADLER. In view of the rudeness of the Committee, I ask unanimous consent to place the gentlewoman's written statement into the record. I assume there will be no objection to that.

Mr. FRANKS. Without objection.

Mr. NADLER. Thank you.

[The prepared statement of Ms. Norton follows:]

ELEANOR HOLMES NORTON
DISTRICT OF COLUMBIA

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEES
RANKING MEMBER, ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS AND EMERGENCY MANAGEMENT
AVIATION
WATER RESOURCES AND ENVIRONMENT

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEES
HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES
FEDERAL WORKFORCE, U.S. POSTAL SERVICE AND LABOR POLICY
GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT

Congress of the United States
House of Representatives
Washington, DC 20515–1501

Statement of Congresswoman Eleanor Holmes Norton
H.R. 7, No Taxpayer Funding for Abortion Act
House Committee on the Judiciary
Subcommittee on the Constitution and Civil Justice
January 9, 2014

Chairman Trent Franks' denial of my request to testify today, particularly in light of the fact that H.R. 7, the No Taxpayer Funding for Abortion Act, singles out the local law and local funds of my district, is an insult to the people I represent and a personal discourtesy from one Member to another. Members of Congress are usually afforded the courtesy of testifying, especially when a bill uniquely affects their district. I had hoped for some modicum of fairness after the controversy generated by the chairman's denial last Congress of my request to testify on his 20-week D.C. abortion ban bill and his denial of my request to testify on the No Taxpayer Funding for Abortion Act before that. Following that controversy, Chairman Franks indicated I could testify on his 20-week D.C. abortion ban bill this Congress, but I declined because he expanded the bill to cover women throughout the United States and not only in D.C.

I strongly oppose this sweeping anti-choice bill in its entirety, but I am specifically compelled to discuss the unique provision that singles out the District of Columbia. Since Republicans assumed the majority in the 112th Congress, based on a platform of local control of local affairs, this subcommittee has been obsessed with dual objectives -- infringing on the District's right to self-government and interfering with the reproductive health of the District's female residents, particularly its low-income women. In three years of Republican control of the House, this is the fourth bill considered by this subcommittee that would both violate my local government's right to self-government and harm its female residents.

H.R. 7 would permanently prohibit the District of Columbia government, but no other local government, from using its local funds for abortion services for low-income women, uniquely denying the District government the right local and state governments exercise to protect the reproductive rights of their female residents. The District of Columbia provision is an attempt to codify a Republican-sponsored appropriations rider that prohibits D.C. from spending its local funds on abortion services for low-income women. The bill also attempts to rewrite history to pretend that Congress did not pass the Home Rule Act of 1973. Under the Home Rule Act, Congress delegated its legislative authority over the District to an elected local government, except for a small number of enumerated exceptions, and the right to reproductive choice was not among those exceptions. H.R. 7 appears to recognize that Congress cannot legislate local law for a local government when it torturously redefines the term "federal government" to include the term "District of Columbia government" for purposes of abortion. In particular, the bill, subject to very limited exceptions, would ban abortions in facilities owned or operated by

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the federal government, which, by definition in H.R. 7, would ban abortions in facilities owned or operated by the D.C. government. Moreover, the bill would prohibit a physician or other individual employed by the federal government from performing an abortion, which, by definition in H.R. 7, would prohibit a physician or other individual employed by the D.C. government from performing an abortion. The contortions upon which this provision depends undermine any basis for its legitimacy.

The District of Columbia is a local jurisdiction of free American citizens, not a colony of the Congress. This bill is a monument to autocracy and a mockery of American democracy. We do not intend to let Republicans get away with supporting democracy everywhere on earth except in our own nation's capital. This bill goes many steps too far outside the realm of our democracy. Not only would this bill harm the women of the United States, it would make matters even worse for the women of the District of Columbia by also eliminating part of the local government's authority to regulate its own affairs and spend its own funds.

Republicans say they support limiting the federal government's power and devolving that power to the states and localities. This bill does the opposite. It uses federal power to snatch local authority from the District of Columbia and its people. Republicans may not want to practice what they preach, but we do not intend to allow them to violate their own principles at our expense.

Mr. FRANKS. And I will now introduce our witnesses.

Helen Alvaré is professor of law at George Mason University School of Law. Professor Alvaré teaches and writes scholarship and public essays in leading newspapers concerning law and policy affecting women, children, and the family. She is co-founder of the grassroots organization, Women Speak for Themselves, and a regular consultant to the official council advising Pope Francis on matters considering women in the church and in the world. We welcome you, Mrs. Alvaré.

Ms. ALVARÉ. Thank you.

Mr. FRANKS. Susan Wood is an associate professor of health policy at the George Washington University School of Public Health and Health Services, and the Director of the Jacobs Institute of Women's Health. Prior to joining George Washington University, Professor Wood served as Assistant Commissioner for Women's Health and Director of the Office of Women's Health at the Federal Drug Administration. Welcome, Ms. Wood.

Richard Doerflinger is the Associate Director of the Secretariat of Pro-Life Activities, United States Conference of Catholic Bishops, where he has worked for 33 years. He is also Adjunct Fellow in Bioethics and Public Policy at the National Catholic Bioethics Center in Philadelphia. We welcome you, Mr. Doerflinger.

Each of the witnesses' written statements will be entered into the record in its entirety. And I ask that each witness summarize his or her testimony in 5 minutes or less. To help you stay within that time, there is a timing light in front of you. The light will switch from green to yellow, indicating that you have 1 minute to conclude your testimony. When of the light turns red, it indicates that the witness's 5 minutes have expired.

Before I recognize the witnesses, it is the tradition of the Committee that they be sworn. So if you will please stand to be sworn.

[Witnesses sworn.]

Mr. FRANKS. You may be seated.

Let the record reflect that the witnesses answered in the affirmative.

And so I would now recognize our first witness, Ms. Alvaré. And if you would please turn your microphone on before speaking. Yes, ma'am.

TESTIMONY OF HELEN M. ALVARÉ, PROFESSOR OF LAW, GEORGE MASON UNIVERSITY SCHOOL OF LAW

Ms. ALVARÉ. Thank you very much. And I would like to thank the Committee for holding this hearing, which even 40 years after Roe versus Wade, is a sign of the power of a human rights dream that refuses to die. No matter how much abortion is legal, Americans, including American women especially, have never and will never make their peace with it. In my remarks today, I am going to address two points: First that neither American law makers, or citizens, especially women, understand abortion as a public good. And second, that abortion is not part of any women's health agenda, even out of the lips of our own Federal Government in its own statements.

In my first point, it's understood by lawmakers and citizens that abortion is different from anything else the Federal Government

might fund. It's unlike the use of the Federal budget, which is for things that support and promote human life versus death, versus insecurity and want. Our Supreme Court has said abortion is not like any other medical procedure. Perhaps this is because, as Justice Stevens and Ginsburg have acknowledged, some of these procedures are "brutal or gruesome," or as Justice Kennedy in a majority has acknowledged, abortion kills. Finally, President Obama has opined that he wishes abortion to be rare and it's a tragic matter. The State legislatures recognize the same thing and have passed a record number of laws restricting abortion in the last 2 years.

Even the most strenuous supporters of legal abortion, Planned Parenthood, has acknowledged that there is, in their words, a baby growing inside a pregnant woman such that abortion ends her life. How disturbing, then, it is that supporters of abortion would continue to urge its funding while acknowledging that it's killing. And the reason they claim is women's health and rights, which is the 800-pound gorilla in the room every time abortion is debated, including today, so let me turn to that.

It's no longer contestable that for decades—and particularly good RAND Corporation study I've cited shows this—women have been more pro-life than men, lesser educated, are more pro-life than the privileged, and the poor are more pro-life than the wealthy. This translates also to the matter of abortion funding, where we have the particularly disturbing data point that the well-off support abortion funding for the poor more than the poor support it for themselves. Investigations of women's voting patterns turn up the same information. Women don't vote because of abortion or in favor of abortion funding.

Finally, when you look at Federal sources or documents that are engaging in promoting women's health, you don't find any mention, let alone promotion, of abortion or abortion funding. The Centers for Disease Control doesn't even keep regular or required records on this. The Federal Government seems decidedly uncurious about abortion and women's health. After Surgeon General Koop in 1989 said studies on the relationship between these were insufficient and recommended long-term studies, the government never did them.

I vividly recall my membership on the NIH council that addresses women's health and asked for one question about abortion and women's health to be put on studies and it never was. Despite the fact that increasingly, European studies, including meta analyses involving 900,000 women, are showing a relationship between abortion and mental health outcomes that are problems for women. In addition to the Federal Government's having no firm ideas about the numbers for abortions or its impact on women, or a lack of curiosity about it, if you look at all the major Federal reports on women's health issued from HHS, from NIH, from the White House, and they are all detailed in my testimony, what do you see in these? When the government is actually dispensing women's health advice? No mention of abortion or abortion funding. Rather, frank acknowledgment that a woman is carrying, in their words, unborn babies. You see them addressing what the CDC identifies as the serious threats to women's health, heart disease, stroke,

cancer; not abortion. You see them recommending that women avoid substances during pregnancy that could "damage your baby."

In conclusion, the Federal Government has collected no useful data about the relationship between abortion and women's health. When it does offer advice, it recommends health care for women and her "unborn baby." Credible studies are indicating distress for women following abortion.

By themselves, these facts indicate how H.R. 7 serves women. But there's another service H.R. 7 might perform. Regular squabbles over Federal funding for abortion too often take the place of debates about what women actually need and say they want. Debates about paid leave or Social Security benefits for women's care work. Instead of debating ideas about how to end poor women's cycle of poverty or non-marital childbearing, we continue to debate abortion in this country. It's time, once and for all, to settle the matter of abortion funding across Federal legislation and move on to a real women's agenda. Thank you.

Mr. FRANKS. Thank you, Ms. Alvaré.

[The prepared statement of Ms. Alvaré follows:]

Testimony of Helen M. Alvaré
Professor of Law
George Mason University School of Law
before the
Subcommittee on the Constitution and Civil Justice
House Judiciary Committee
January 9, 2014
Hearing on H.R. 7, No Taxpayer Funding for Abortion Act

Thank you very much for this opportunity to testify. I propose to outline why it serves the interests of American women for the federal government once and for all to remove itself from the business of abortion funding.

Preliminarily, I would like to thank this subcommittee for holding such a hearing in this 41st year after the Supreme Court overturned the abortion laws of the 50 states. This bill shows the power of a dream of human rights that cannot be extinguished, no matter the amount of money or powers arrayed against it. Americans, including American women, have never made and will never make our peace with abortion. It is a feature of U.S. culture I hear admired in my work all over the world. Abortion is not a social good deserving of federal funding, let alone funding in the name of women's health or well-being.

In my remarks today, I will address the following points: First, that neither American lawmakers nor citizens, especially women, understand abortion as a public good meriting funding. And second, that abortion is not a part of any genuine "women's health" agenda according to the federal government's own statements.

On my first point: abortion is understood both by lawmakers and citizens to be different from all other projects, programs or procedures receiving federal funding. The federal budget is broadly devoted to national security, social safety nets, health care, veterans, federal retirement, safe food and drugs, the environment, and investments in education, scientific and medical research, and infrastructure.[1] These support and promote human life versus death, insecurity, and want. But abortion, in the words of our Supreme Court, is different. Even if the Court doesn't get its biology exactly right, it has said that "no other procedure involves the purposeful termination of potential human life."[2] Even Supreme Court Justices explicitly supporting legal abortion acknowledge abortion's uniquely problematic nature. Justices Stevens and Ginsburg in *Stenberg v. Carhart* wrote that both dismemberment abortions and partial birth abortions are "equally" "gruesome" and "brutal," and that neither one "is more akin to

[1] Center for Budget and Policy Priorities, *Where Do Our Federal Tax Dollars Go?* at http://www.cbpp.org/cms/?fa=view&id=1258.
[2] *Harris v. McCrae,* 488 U.S. 297, 325 (1980).

infanticide than the other."[3] Justice Kennedy's majority opinion in the second partial birth abortion case, *Gonzales v. Carhart,* said abortion "extinguish[es] life"[4] and repeatedly wrote that abortion "kill[s]".[5] Finally President Obama has opined that he wishes abortion to be "rare" and that it is a "tragic" matter.[6]

Lawmakers at the state level witness similarly to the nation's refusal to make peace with abortion. According to the Guttmacher Institute, 205 restrictions on abortion were enacted in the States between 2011 and 2013, a record pace.[7]

And even the most strenuous supporters of legal abortion -- even a leader of the huge abortion provider Planned Parenthood -- acknowledge that there is a baby growing inside a pregnant woman such that abortion ends a life.[8] Having been an observer of the abortion debate for decades, I want to highlight how newly disturbing it is when supporters of legal abortion cease denying that abortion destroys a human life, while continuing to demand legal abortion and abortion funding. They do so in the name of women's health and rights, which is the 800 lb. gorilla in the room every time abortion is legally debated, including here today. So let me turn to the matter of women's beliefs and women's health in relation to abortion.

First, it is no longer contestable that women embrace the pro-life label and positions as much or more than men, and that poor women are somewhat more pro-life than the wealthier. A terrific and quite detailed study issued by the Rand Corporation in cooperation with the Packard, Hewlett and Rockefeller Foundations[9] -- after calling abortion an "enduringly divisive issue" in the American political landscape [10] -- reported stable attitudes on abortion over decades. According to their crosstabs, females survey a few percentage points more pro-life than men – a figure within the margin of error, but persistent over decades and therefore significant.[11] Also the less educationally privileged are more pro-life than the privileged, sometimes by

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[3] 530 U.S. 914, 946 (2000).
[4] 550 U.S. 124, 128 (2007).
[5] 550 U.S. 124, 129, 136, 151, 152, 154.
[6] Sheryl Gay Stolberg, On Abortion, Obama Is Drawn Into Debate He Hoped to Avoid, *The New York Times*, May 14, 2009, at http://www.nytimes.com/2009/05/15/us/politics/15abortion.html?
[7] Guttmacher Institute Media Center, *More State Abortion Restrictions were Enacted in 2011-13 than in Entire Previous Decade*, Jan. 2, 2014 at http://www.guttmacher.org/media/inthenews/2014/01/02/index.html.
[8] *See e.g.* Faye Wattleton, *How to Talk to your Child about Sexuality* (New York: Doubleday Inc., 1986); Leslie Cannold, *The Abortion Myth: Feminism, Morality and the Hard Choices Women Make* (Connecticut: Wesleyan University Press, 1998), xvii-xviii.
[9] David M. Adamson, *et al., How Americans View World Population Issues: A Survey of Public Opinion* (A Rand Program, supported by the David and Lucille Packard, William and Flora Hewlett and Rockefeller Foundations: 2000); at http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1114.pdf.
[10] *Id.* at 54.
[11] *Id.* at 57.

margins of 33 or even 45%. And the poor are more pro-life than the wealthy by 16 to 25%.[12]

These differences persist on the question of abortion funding. To wit: a majority of the public opposes government funding for abortion; women oppose funding by a few percentage points more than men, the more educationally privileged support funding more than the less privileged; and the well-off support abortion funding for the poor more than the poor favor it for themselves,[13] this last a particularly unpleasant fact.

Investigations of what drives women's voting also fail to turn up any special female support for abortion[14] or abortion funding. Women vote on the economy, jobs, and general social welfare spending, along with their perception of which candidate really cares about the people she or he will serve.[15] If you glance at the League of Women voters website, you will find it highlighting voting rights, gun safety, campaign finance and the environment,[16] not abortion, not abortion funding.

Finally, when you look at federal sources and documents and experts engaging and promoting women's health, you notice two things. First, the federal government is decidedly uncurious about the role abortion plays respecting women's health. The Centers for Disease Control ("CDC") doesn't even require mandatory reporting by the states and consequently doesn't have complete or standardized data on abortion.[17] In 1989, Surgeon General Koop concluded after a complete review of then-existing material on the effect of abortion on women's health, that available studies were insufficient. He recommended that "consideration be given to going forward with an appropriate prospective

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[12] *Id.* at 58.
[13] *Id.* at 59-60.
[14] Karen Kauffmann, *Unconventional Wisdom: Facts and Myths about American Voters*, 106-107 (2008).
[15] Libby Copeland, Why Do Women Vote Differently Than Men? *Slate.com*, Jan. 4, 2012, at http://www.slate.com/articles/double_x/doublex/2012/01/the_gender_gap_in_politics_why_do_women_vote_differently_than_men_.html; Kira Sanbonmatsu, *The Quest for Women's Votes in 2012*, Scholars Strategy Network, Aug. 2012, at http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_sanbonmatsu_on_the_gender_gap.pdf (which also reported that "[h]ot-button reproductive issues like abortion do not drive the gender gap in voting because most men and women hold parallel attitudes on these issues.").
[16] http://www.lwv.org/our-work (visited week of Jan 1-8, 2014).
[17] Centers for Disease Control, *CDC's Abortion Surveillance System FAQs*, at http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm ("Are states required to report their abortion statistics to CDC? No, states and areas voluntarily report data to CDC for inclusion in its annual Abortion Surveillance Report. CDC's Division of Reproductive Health prepares surveillance reports as data become available. There is no national requirement for data submission or reporting.").

study."[18] But the government has not undertaken such a project, to this day. I vividly recall during my membership on the National Advisory Child Health and Human Development Council in the early 2000s asking personally and repeatedly for even one question about abortion on long-term surveys about women's health, only to be continually put off, despite abortion then and now, being performed upon women about 3300 times each day of the week. This lack of federal curiosity persists despite increasing evidence from well-regarded European studies – following hundreds of thousands of women for their entire lives[19] -- and a more recent meta-analysis in the *British Journal of Psychiatry* involving studies comprehending nearly 900,000 women, showing that abortion is associated with significantly increased post-abortion risk of several problematic mental health outcomes.[20]

Second on the matter of women's health and abortion, in addition to the federal government's having no firm idea about total numbers of abortions, or abortion's impact on women's health, and no real curiosity on the matter, it also appears that when the federal government *is* acting seriously on behalf of women's health – via women's health initiatives for example from the National Institutes of Health ("NIH") or the White House, or the Department of Health and Human Services – that it does not raise the subject of any health "need" for abortion, let alone abortion funding. Take a look, for example, at recent, significant federal initiatives on women's health, like NIH's strategic plan for women's health and sex differences research for 2010–2020,[21] or the Department of Health and Human Services' Office on Women's Health report entitled *A Lifetime of Good Health: Your Guide to Staying Healthy,*[22] or HHS' websites for women and girls which it calls "comprehensive" regarding women's or girls' health,[23] or HHS' Healthypeople 2020 initiative, providing "science-based, 10-year national objectives for improving the health of all

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[18] Letter from Surgeon General C. Everett Koop to President Ronald Reagan, Jan 9. 1989, reprinted at http://www.priestsforlife.org/postabortion/89-01-09koop.htm.

[19] *See, e.g.* David *et al.,* Postpartum and Postabortion Psychotic Reactions, 13 *Family Planning Perspectives* 88, 89(1981); Gissler *et al.*, Suicides after Pregnancy in Finland, 1987-94; Register Linkage Study, 313 *British Medical Journal*, 1996; 313: 1431-34.

[20] Priscilla K. Coleman, Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009, 199 *The Brit. J. of Psychiatry* 180 (2011) (moderate to highly increased risk of mental health problems after abortion); Morgan *et al.,* Letters, 314 *British Medical Journal* 903 (1997). Another study supporting the former explanation was published by L.G. Peppers, "Grief and Elective Abortion: Implications for the Counselor," in Kenneth J. Doka, ed., *Disenfranchised Grief: Recognizing Hidden Sorrow* (MD: Lexington Books 1989),135 (Grief measurements of the same women pre- and post-abortion showed that significantly different groups of women suffered high grief reaction scores at the two points in time.).

[21] Office of Research on Women's Health, National Institutes of Health, *Moving into the Future With New Dimensions and Strategies: A Vision for 2020 for Women's Health Research* (2010) (NIH Publication 10-7606), at http://orwh.od.nih.gov/research/strategicplan/ORWH_StrategicPlan2020_Vol1.pdf.

[22] U.S. Dept. of Health and Human Services' Office on Women's Health, *A Lifetime of Good Health: Your Guide to Staying Healthy*, at http://womenshealth.gov/publications/our-publications/lifetime-good-health/lifetimegoodhealth-english.pdf.

[23] *Id.* at 2; www.womenshealth.gov; www.girlshealth.gov.

Americans,"[24] or the White House Council on Women and Girls' report *Women in America: Indicators of Social and Economic Well-Being.*[25] What do we find in these many lengthy and comprehensive compilations of women's health needs, and actual health advice to American women from their federal government?

We find frank acknowledgement that a pregnant woman is carrying an "unborn baby" and reference to human life beginning at conception.[26] We find a lot of advice about what the CDC identifies as the leading threats to women's health,[27] threats like heart disease, stroke, and cancer. We find advice and promises regarding future research upon diseases women suffer more or differently than men.[28] We find attention to the highlighted health problem of women's infertility or difficulties carrying a pregnancy to term, as well as attention to avoiding substances during pregnancy that could "damage ... your baby." [29]

In conclusion, the federal government has collected no dispositive data about the relationship between abortion and women's health. When it addresses women's health priorities, it rather offers advice to women about caring for their unborn child, and says nothing about abortion as health care. Credible studies indicate an association between abortion and mental distress for some women. There is no empirical basis therefore, upon which federal lawmakers can make the claim that women's health is promoted by funding abortion. By themselves, these facts indicate how H.R. 7 serves American women. But there is another service for women H.R. 7 might well perform. Regular squabbles over federal funding for abortion across myriad pieces of legislation seem to have taken the place of an actual legislative agenda for women's actual needs. Instead of debating policies supporting women's care work, or work/family balance, policies addressing paid leave or social security benefits -- instead of debating ideas about enabling poor women especially to break the cycle of poverty and nonmarital childbearing -- Congress continually debates abortion funding. It is time once and for all to settle the matter of federal funding for abortion, and move on to a real women's agenda.

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[24] www.healthypeople.gov/2020/default.aspx.
[25] While House Council on Women and Girls, *Women in America: Indicators of Social and Economic Well-Being* (2011), at www.whitehouse.gov/administration/eop/cwg/data-on-women#Population.
[26] U. S. Department of Health and Human Services, Office on Women's Health, *A Lifetime of Good Health: Your Guide to Staying Healthy*, 35-36 (hereafter "Staying Healthy"), at http://womenshealth.gov/publications/our-publications/lifetime-good-health/lifetimegoodhealth-english.pdf.
[27] Centers for Disease Control, *Leading Causes of Death by Race/Ethnicity, All Females – United States 2010*, at http://www.cdc.gov/women/lcod/2010/WomenRace_2010.pdf.
[28] Office of Research on Women's Health, National Institutes of Health, *Moving into the Future With New Dimensions and Strategies: A Vision for 2020 for Women's Health Research* (2010), at http://orwh.od.nih.gov/research/strategicplan/ORWH_StrategicPlan2020_Vol1.pdf.
[29] U.S. Dept. of Health and Human Services, *Staying Healthy*, at 34, 36.

Mr. FRANKS. And I now recognize our second witness, Ms. Wood.

TESTIMONY OF SUSAN FRANKLIN WOOD, ASSOCIATE PROFESSOR OF HEALTH POLICY, DIRECTOR, JACOBS INSTITUTE OF WOMEN'S HEALTH, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES, GEORGE WASHINGTON UNIVERSITY

Ms. WOOD. Thank you, Mr. Chairman. And gentlemen of the Committee. I want to thank you for being able to present remarks on the bill before us today, H.R. 7. I need to point out that this sweeping legislation would affect nearly all women in this country and would do significant harm to many, especially those women and families who are struggling to make ends meet. While the bill is cloaked in the language of taxpayer rights and Federal appropriations, a close examination of its true impact reveals an attempt to interfere with a women's personal decision making by denying women insurance coverage for abortion care. And every woman deserves coverage for basic health care, including contraception, maternity care, and abortion coverage, should she need it.

This legislation reaches far beyond the already troublesome Hyde Amendment, beyond the onerous restrictions that were proposed in the Stupak Amendment, in the Affordable Care Act, and beyond the restrictions that actually were enacted into the ACA by the Nelson Amendment. It would virtually eliminate abortion coverage from the private insurance market and impose unprecedented new tax burdens on business that want to offer abortion coverage to their employees.

Moreover, it would provide exceptions only for rape and incest, or for conditions that put a woman in danger of death. Congress should reject this harmful and overreaching piece of legislation.

Now, those who oppose abortion have tried and failed to make it illegal. So instead they have worked to make it almost impossible to obtain. Indeed some object to even insurance company of contraception, which is the most effective way to prevent unplanned pregnancy and reduce the need for access to abortion care. This bill is the most recent attempt. And it is not enough that they have tried to deny abortion coverage to the women who qualify for Medicaid. It is not enough that this denies coverage to veterans, Federal employees, Native American women, disabled women, and women who participate in other Federal insurance plans and programs.

No, to cut off access to affordable abortion care for the rest of the women in the country, we need this bill as the final piece of the puzzle. If Congress enacts this bill, you are taking away coverage from women who live in places where private insurance plans that include abortion coverage are sold today. And you would take away a woman's ability to use her own health savings account to cover her medical costs related to abortion care, an unprecedented insertion of abortion politics into tax policy.

Historically, the vast majority of insurance plans have typically covered abortion services. It's no coincidence, it's where health policy—good health policy meets good financial policy and meets a woman's health care needs. In our analysis of both the Stupak and Nelson Amendments, which I would like to enter into the record, we raise the concern that Congress would create a chilling effect which would lead many more women to lose abortion coverage.

Further changing the tax benefits for employees and for employers providing health coverage as proposed in H.R. 7 could create a tipping point in the nature of insurance whereby women lose abortion coverage because insurers may no longer provide plans that include it.

Since approximately 60 percent of women of reproductive age, 37 million women, get their health care coverage through private insurance, this legislation could have a far-reaching effect. It represents more than just meddling in their personal decisions, by making it unaffordable, it effectively bans abortion for some women. And while it may not seem like a big expense to a Member of Congress, in these tough financial times for many people, abortion care costs more than their monthly rent, putting it out of reach for their family's pocketbook.

Moreover, cutting off access to abortion has profoundly harmful effects on the public health. Based on the experience with the ban that has long been imposed on women who qualify for Medicaid, we know that some who seek an abortion are forced to carry a pregnancy to term, due to lack of coverage and cost. And we also know that births that result from unintended or closely spaced pregnancies are associated with delayed prenatal care, premature birth, low birth weight, and other negative health effects on the children. We know that a woman who wants to get an abortion but is denied it is less likely to have a full-time job and twice as likely to be a victim of domestic violence. Denying abortion care to these women who are least able to afford out-of-pocket medical expenses will further exacerbate existing health disparities.

And although most of the women affected by these bans will still find a way to end their pregnancies. Many are forced to delay their procedures for 2 or 3 weeks or longer while they pull together enough money to pay for the care they need. By banning abortion coverage for even more women through private insurance, as this bill would do, Congress would expand the number of women and families struggling with budget dilemmas, including many middle-class families still recovering from the great recession. And even with the primary assistant provided by the Affordable Care Act, families have to stretch their budgets to pay for health insurance, and women are more likely to fall into poverty if they are not able to get the abortion they need.

Importantly, the H.R. 7 also extends very narrow exceptions for abortion coverage now allowed for Medicaid. If private plans decided to continue to provide such coverage, both they and the IRS would need to evaluate coverage decisions to ensure that they were in compliance. Neither the private market nor the IRS is suited for such determinations about a woman's risk of death or determination of rape or incest. Women potentially could be required to provide evidence of rape or incest to the insurer or to the IRS as part of a claim.

Furthermore, health conditions, such as diabetes, hypertension, epilepsy, or others would not necessarily fit the definition of placing a woman in danger of death, but could have potentially serious consequences for her health. Health insurance now routinely covers the range of pregnancy and other health services that may be needed by the individual woman. But by denying abortion coverage, it

would not only change the current insurance women have, but would put some women's health at risk.

In conclusion, this bill would impose a sweeping and unprecedented ban on abortion coverage with far-reaching and harmful consequences for women's health and for their economic security. When it comes to the most important decision in life, such as whether to become a parent, it is vital that a woman be able to consider all of her options, no matter what her income or source of insurance. It makes sense that health insurance covers the whole spectrum of women's health needs, including birth control, abortion, maternity care. Because when people can plan if and when to have children, it's good for them, it's good for their families, and it's good for society as a whole. Thank you.

[The prepared statement of Ms. Wood follows:]

United States House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution and Civil Justice

Hearing on the No Taxpayer Funding for Abortion Act

Susan Franklin Wood
Associate Professor of Health Policy
Director, Jacobs Institute of Women's Health
School of Public Health and Health Services
George Washington University

January 9, 2014

Mr. Chairman and Distinguished Members of this Subcommittee:

Thank you for the opportunity to appear before you today to present remarks on the "No Taxpayer Funding for Abortion Act."

This bill is a sweeping piece of legislation that would affect nearly *all* women in this country and would do significant harm to many, especially those women and families who are struggling to make ends meet. While the bill is cloaked in the language of taxpayer rights and federal appropriations, a close examination of its true impact reveals a mean-spirited attempt to interfere with a woman's personal decision-making by denying women insurance coverage for abortion care. Every woman deserves coverage for basic health care, including contraception, maternity care and abortion services should she need it.

This legislation reaches far beyond the already troublesome Hyde Amendment, which as you know is an annual appropriations measure that withholds abortion coverage for women enrolled in Medicaid unless their life is endangered by a pregnancy or the pregnancy results from rape or incest. And it reaches beyond the onerous restrictions that were proposed in the Stupak Amendment to the Affordable Care Act (ACA) and beyond the restrictions enacted into the ACA by the Nelson Amendments. In addition to all of those harsh measures, it would also virtually eliminate abortion coverage from the private insurance market and deny tax credits to small businesses that want to offer abortion coverage to their employees. Moreover, it would provide exceptions only for rape and incest or for conditions that put a woman in danger of death.

Congress should reject this harmful and overreaching piece of legislation.

The Bill Would Ban Abortion Coverage for Virtually All Women in this Country, Including Those in the Private Insurance Market

Those who oppose abortion have tried and failed to make it illegal, so instead they have worked to make it almost impossible to obtain. Indeed, some object even to insurance coverage of

contraception, the most effective way to prevent unplanned pregnancy and reduce the need for abortion.

One of the ways they have accomplished this goal of limiting access to abortion is to make it unaffordable. This bill is their most recent attempt to place affordable abortion care out of reach for even more women.

For those who would make abortion illegal, it is not enough that they have tried to deny abortion coverage to the 9.7 million women who are currently enrolled in Medicaid[1] and up to 4.6 million more women who will become subject to the original abortion coverage ban if all the states take up the Medicaid expansion under the ACA.[2]

It is not enough that they have denied coverage to women who participate in other federal insurance plans and health programs, making them pay out-of-pocket for abortion care. This includes service women, veterans, and military dependents; federal employees; women in federal detention; Native American women; adolescents in the Children's Health Insurance Program; disabled women enrolled in Medicare; and Peace Corps volunteers.

The Impact on the Private Insurance Market

No, in order to cut off access to affordable abortion care for the rest of the women in the country, abortion opponents need this bill as the final piece of the puzzle. If Congress enacts this bill into law, you are taking away coverage from women who live in places where private insurance plans that include abortion coverage are sold today. And you would take away a woman's ability to use her own health savings accounts to cover her medical costs related to abortion care – an unprecedented insertion of abortion politics into tax policy.

Historically, the vast majority of insurance plans have typically covered abortion services. It is no coincidence—it's an instance where good health policy meets good financial policy to address a woman's health care needs. In our analysis of both the Stupak and Nelson amendments, we raised the concern that Congress would create a chilling effect on plans by creating burdensome accounting requirements and would lead many more women to lose abortion coverage. Adding to the restrictions already in place in the ACA, further changing the tax credits for individuals and for small employers providing health care coverage could lead to significant changes in the health insurance coverage that women have had, potentially creating a "tipping point" in the nature of health insurance whereby women lose abortion coverage entirely.[3] It is the nature of health insurance that insurers may no longer provide plans that

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[1]Guttmacher Institute, Unpublished tabulations using the 2012 and 2013 Current Population Survey (CPS), March Supplements.

[2] Kenney G, et. al. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" *Urban Institute, Timely Analysis of Immediate Health Policy Issues* (Summer 2012). Available at:http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

3 Rosenbaum S, Cartwright-Smith L, Margulies, R, Wood S, and Mauery D. An Analysis of the Implication of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions. (George Washington University School of Public Health and Health Services, Dept of Health Policy, 2009).

include coverage which would come with burdensome regulatory requirements such as proposed in H.R. 7. Since approximately 60% of women of reproductive age, or 37 million women, get their health coverage through private insurance, this legislation could have a profound effect.[4]

This Bill Would Affect All Women, And Especially Hurt the Most Vulnerable Women

This bill represents more than just meddling in women's personal decisions; by making abortion care unaffordable, it will effectively ban abortion for some women. While it may not seem like a big expense to a Member of Congress, in these tough financial times, for many people, abortion care costs more than their monthly rent, putting it out of reach for their family's pocketbook. Studies show that most Americans do not have enough savings to cover a financial emergency, which means they have to borrow, sell or pawn personal items, or divert money from another financial obligation to cover emergencies such as an unexpected health care need.[5]

Moreover, cutting off access to abortion has profoundly harmful effects on the public health. Based on the experience with the ban that has long been imposed on women who qualify for Medicaid, we know that one in four low-income women who seek an abortion are forced to carry a pregnancy to term due to lack of coverage and cost.

- Births which result from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes. These include delayed prenatal care, premature birth, low birth weight, and other negative health effects for children.
- A woman who wants to get an abortion but is denied is less likely to have a full-time job and twice as likely to be a victim of domestic violence.[6]
- Women with lower socioeconomic status – in other words, those who are least able to afford out-of-pocket medical expenses – already experience disproportionately high rates of adverse health conditions. Denying them access to abortion care will only exacerbate existing health disparities.

Although most of the women affected by these bans still find a way to end their pregnancies, they often do so at great personal cost. Many are forced to delay their procedure for as long as two to three weeks while they pull together enough money to pay for the care they need, with the price and risks of the procedure increasing the longer they wait. By banning abortion coverage for even more women through private insurance, as this bill would do, Congress would expand

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[4] Guttmacher Institute, Unpublished tabulations using the 2012 and 2013 Current Population Survey (CPS), March Supplements.

[5] Center for Reproductive Rights, "Women's Reproductive Rights in the United States: A Shadow Report" (June 2006). Available at http://www2.ohchr.org/english/bodies/hrc/docs/ngos/CRR.pdf. *See* also Biggs et al., "Understanding why women seek abortions in the US." *BMC Women's Health,* 13:29 (2013). Available at http://www.ansirh.org/wp-content/uploads/2013/06/biggs_gould_foster_whi7-2013.pdf.

[6] Biggs et al., "Understanding why women seek abortions in the US." *BMC Women's Health*, 13:29 (2013). Available at http://www.ansirh.org/wp-content/uploads/2013/06/biggs_gould_foster_whi7-2013.pdf.

the number of women and families struggling with unsolvable budget dilemmas, including many middle class families still recovering from the Great Recession.

In the current insurance market, coverage denial policies such as the ones proposed in this bill can have a serious and detrimental effect on people's financial security. Even with the premium assistance provided by the Affordable Care Act, there are individuals and families who have to stretch their budgets to pay for health insurance, leaving no margin to pay for medical costs that are not covered by their plans. When policymakers deny abortion coverage and make these health services unaffordable, it can jeopardize a family's financial security. When a woman is living paycheck to paycheck, denying coverage for an abortion can push her deeper into poverty. Indeed, studies show that a woman who seeks an abortion but is denied is three times more likely to fall into poverty than one who is able to get an abortion.[7]

Limited exceptions only for rape, incest or danger of death

H.R. 7 limits abortion coverage to the current exceptions in Medicaid coverage: in cases of rape, incest or if the woman is in danger of death. These narrow exceptions, now in place for women covered by Medicaid in all but 15 states, would be further extended into the private market. Though plans could follow the coverage exemptions in Medicaid, it would be simpler for them to exclude abortion coverage in all circumstances. If choosing to cover the exceptions, then both private health plans and the IRS would need to make determinations of the nature of plan coverage as well as evaluate coverage decisions to ensure that they were in compliance. Neither the private market nor the IRS is suited for such determinations about a woman's risk of death or determination of rape or incest. Women potentially could be required to provide evidence of rape to the insurer as part of a claim.

The need for access to abortion to protect the health of women, not just when they are in danger of imminent death, is critical. As stated by the American Congress of Obstetricians and Gynecologists when the House considered this legislation during the 112th Congress, this bill "would leave women whose health is seriously threatened by their pregnancies with limited access to the care their doctors recommend to protect their health." Health conditions, such as diabetes, hypertension, epilepsy or others would not necessarily fit the definition of placing a woman in "danger of death," but could have potentially serious consequences for her health. Health insurance currently routinely covers the range of pregnancy care and other health services that may be needed by any individual woman. By denying abortion coverage, this would not only change the current insurance women have, but would put some women's health at risk.

In conclusion, this bill would impose a sweeping and unprecedented ban on abortion coverage, with far-reaching and harmful consequences for women's health and economic security. When it comes to the most important decisions in life, such as whether to become a parent, it is vital that a woman be able to consider all her options--including an abortion-- no matter what her income or source of insurance. It makes sense that health programs cover the whole spectrum of women's reproductive health needs, including birth control, abortion, and childbirth, because when people can plan if and when to have children, it's good for them and for society as a whole.

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[7] *Id.*

Mr. FRANKS. Now recognize our third and final witness, Mr. Doerflinger. Please turn on your microphone, sir.

TESTIMONY OF RICHARD M. DOERFLINGER, ASSOCIATE DIRECTOR, SECRETARIAT OF PRO-LIFE ACTIVITIES, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

Mr. DOERFLINGER. Thank you, Mr. Chairman, for this opportunity to voice the support of the U.S. Conference of Catholic Bishops, for H.R. 7, the "No Taxpayer Funding for Abortion Act." This bill will write into permanent law a policy on which there's been strong popular and Congressional agreement for over 35 years: the Federal Government should not use its funding power to support or promote abortion. This principle has been embodied in the Hyde Amendment, and numerous other provisions governing a wide range of domestic and foreign programs. It has consistently had the support of the American people. Women oppose federally funded or federally mandated abortion coverage as strongly as men or more so. Low-income Americans oppose it more strongly than the affluent.

And even courts insisting on a constitutional right to abortion have said this alleged right "implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds." In 1980, the U.S. Supreme Court said the Hyde Amendment is an exercise of "the legitimate congressional interest in protecting potential life," adding: "Abortion is inherently different from other medical procedures because no other procedure involves the purposeful termination of a potential life."

In other words, the Federal Government is perfectly within its moral and legal rights, to say that abortion is not basic health care. The only mistake in the quote from the Supreme Court is its use of the phrase "potential life." That has no clear biological or medical meaning. In fact, unborn children are actually alive until they are made actually dead by abortion. More recently, the Supreme Court has said simply that the government may express "profound respect for the life of the unborn" by regulating abortion.

So the Supreme Court and the actions of Congress simply contradict Dr. Wood's testimony. She's talking about the government "meddling," "interfering," "denying," "making women lose" coverage—setting aside the fact that the vast majority of women don't want abortion in their coverage, so saying you are losing the coverage is like saying you're losing a tumor—"banning" abortion, "forcing." This is simply a governmental decision to put its support behind the life-affirming options for mother and child and not to subsidize the lethal option.

Congress's policy has been consistent for decades, but its implementation in practice has been piecemeal, confusing, and sometimes inadequate. Gaps or loopholes have been discovered in its patchwork of provisions over the years, highlighting the need for a permanent and consistent policy across the Federal Government.

In 2010, Congress passed major health care reform legislation, which, as has been mentioned, puts Federal funds into an entirely new part, a much larger part of the health care system for the first time. And that legislation has, as my longer statement details, at

least four different policies on abortion funding, ranging from a ban on such funding in one section, on school-based clinics, to a potential mandate for such funding in another. These problems have arisen partly because various sections of the Affordable Care Act not only authorize but appropriate their own funds, thus bypassing the Hyde amendment and similar longstanding appropriations provisions.

Recent developments underscore a need to correct the abortion funding problems in the Affordable Care Act. In 2010, the Act was used to approve direct Federal funding of elective abortion coverage in the State high risk pool program until that was uncovered by pro-life groups.

As State health exchanges have begun to operate, Americans are finding it difficult to find plans without abortion coverage or even to get clear answers as to which plans those are. And they are discovering that despite public assurances to the contrary, they may, in fact, be forced by the government to subsidize other people's abortions as a condition for obtaining the health care their families need.

Congressional employees and Members of Congress are finding that if they want a plan without abortion in D.C., they only have a choice of nine out of 120—more than 120 plans. Members and staff of Congress, previously assured they are free to choose from a full range of plans without abortion, are being deprived of that freedom or having it greatly narrowed—contrary, in our view, to longstanding Federal law. We have submitted comments to the Federal Government on that point.

If a bill like H.R. 7 had been enacted before the health care reform debate began, that debate would not have been about abortion funding. A major obstacle to support by Catholics and other prolife Americans would have been removed, and the legislation would not have been so badly compromised by provisions that place unborn human lives at great risk.

H.R. 7 would prevent problems and confusions on abortion funding in future legislation. Federal health bills—and I think a lot of us would be relieved at this—could be debated in terms of their ability to promote the goal of universal health care, real health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly health care at all.

Finally, in our view, and we'd be happy to discuss this, H.R. 7 does not eliminate private coverage for abortion, but specifically allows it when purchased without Federal subsidy. And it does not create an unprecedented policy of denying tax benefits to abortion. The Affordable Care Act already broke that precedent by creating a system of tax credit subsidies for coverage, which the Act itself referred to as Federal funding. My prepared text provides additional details, and I'd be happy to answer questions. Thank you.

[The prepared statement of Mr. Doerflinger follows:]

Testimony of Richard M. Doerflinger
on behalf of the
United States Conference of Catholic Bishops
before the
Subcommittee on the Constitution and Civil Justice
House Judiciary Committee
January 9, 2014

Hearing on H.R. 7, No Taxpayer Funding for Abortion Act

I am Richard M. Doerflinger, Associate Director of the Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops (USCCB). I want to thank this Subcommittee for allowing us to present our views in support of H.R. 7, the No Taxpayer Funding for Abortion Act.

A Permanent Ban on Abortion Funding: Long Overdue

H.R. 7 will write into permanent law a policy on which there has been strong popular and congressional agreement for over 35 years: The federal government should not use tax dollars to support or promote elective abortion.[1]

Since 1976 this principle has been embodied in the Hyde amendment to annual appropriations bills funding the Department of Health and Human Services (HHS), and in numerous similar provisions governing a wide range of domestic and foreign programs. It has consistently had the support of the American people. For example, reflecting a long history of public support for the Hyde amendment, an April 2011 CNN survey found that Americans oppose "using public funds for abortions when the woman cannot afford it" by a margin of 61% to 35%.[2] In December 2009 a Quinnipiac University poll found 72% opposition to "allowing abortions to be paid for by public funds under a health care reform bill." In a survey conducted

[1] In this testimony the phrase "elective abortion" refers to abortions that have long been ineligible for federal funding; in recent years this has included abortions except for cases of rape, incest, or danger to the life of the mother. The term is used here as shorthand for a longstanding federal policy, not as expressing a medical or moral judgment.

[2] CNN/Opinion Research Corporation Poll of April 9-10, 2011, cited at www.pollingreport.com/abortion.htm. The same question in 2009 elicited an almost identical response, with public funding of abortion opposed by a margin of 61% to 37%. The 2009 poll even found a majority against companies including abortion in private insurance plans involving no government money, 51% to 45%. See CNN/Opinion Research Corporation Poll of November 13-15, 2009, at http://i2.cdn.turner.com/cnn/2010/images/03/09/rel7.pdf.

for my organization by International Communications Research at about the same time, 67% (including 60% of those supporting health care reform legislation) opposed "measures that would require people to pay for abortion coverage with their federal taxes." That survey also asked: "If the choice were up to you, would you want your own insurance policy to include abortion?" Only 24% said yes; 68% of U.S. adults, and *69% of women*, said *no*. Also saying *no* were 82% of those who were uninsured, presumably the primary target audience for health care reform.[3] Finally, in a March 2013 poll by The Polling Company, Inc., respondents opposed using tax dollars to pay for abortion by a margin of 58% to 35%.[4]

Even public officials who take a "pro-choice" stand on abortion have supported bans on public funding as a "middle ground" on this contentious issue – in recognition of the fact that it is not "pro-choice" to force others to fund a procedure to which they have fundamental objections. And even courts insisting on a constitutional "right" to abortion have said that this alleged right "implies *no limitation* on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds."[5] As the U.S. Supreme Court said in 1980:

> By subsidizing the medical expenses of indigent women who carry their pregnancies to term while not subsidizing the comparable expenses of women who undergo abortions (except those whose lives are threatened), Congress has established incentives that make childbirth a more attractive alternative than abortion for persons eligible for Medicaid. These incentives bear a direct relationship to *the legitimate congressional interest in protecting potential life*. Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions. *Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life*.[6]

The Court's only error here was its use of the vague and incoherent term "potential life." The unborn child is actually (not just potentially) alive, unless he or she is made actually (not just potentially) dead by abortion. Later Supreme Court decisions have recognized this, saying more

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[3] These and other recent polls are summarized in National Right to Life Committee, "Public opinion on 'health care reform' and abortion," January 6, 2010, at http://www.nrlc.org/uploads/ahc/AHCPollsSummary.pdf . For more on the ICR survey see USCCB News Release, "New Survey: Most Americans Want Health Care Reform, Oppose Abortion Coverage, Support Conscience Protection Laws," September 22, 2009, at www.usccb.org/comm/archives/2009/09-186.shtml.

[4] See National Right to Life Committee News Release, "New Polling Shows Strong Support for Prohibiting Abortion on Pain-Capable Unborn Children." April 22, 2013, at https://www.nrlc.org/communications/releases/2013/release042213/.

[5] *Maher v. Roe*, 432 U.S. 464, 474 (1977) (emphasis added).

[6] *Harris v. McRae*, 448 U.S. 297, 325 (1980) (footnotes omitted, emphasis added). Note that this court decision upheld the original Hyde amendment of Fiscal Year 1977, which allowed federal abortion funding only in cases of danger to the life of the mother; that policy was also in effect from 1981 to 1993.

directly that by regulating abortion "the State . . . may express profound respect for the *life* of the unborn."[7] Most recently, in their decision upholding the federal ban on partial-birth abortion, the justices reaffirmed government's "legitimate interests in regulating the medical profession in order to promote *respect for life, including life of the unborn*."[8]

So secure is this legal and political consensus against public funding of abortion, in fact, that some have *assumed* it is already fully implemented at all levels of our federal government. For example, some wrongly argued during the recent debate on health care reform that there was no need for restrictions on abortion funding in the legislation, because this matter had already been settled by the Hyde amendment. However, the Hyde amendment itself is only a rider to the annual Labor/HHS appropriations bill, and thus governs only funds appropriated under that particular Act.

The fact is that Congress's *policy* has been remarkably consistent for decades, but the implementation of that policy in *practice* has been piecemeal, confusing and sometimes sadly inadequate. Federal funds are prevented now from funding abortion by riders to a number of annual appropriations bills, as well as by provisions of specific authorizing legislation for programs such as the Department of Defense, Children's Health Insurance Program, Title X family planning, and foreign assistance.

Past Federal Action to Ensure a Consistent Abortion Funding Policy

On occasion a gap or loophole has been discovered that does not seem to be addressed by this patchwork of provisions, highlighting the need for a permanent and consistent policy to be applied across the federal government:

- In 1979, Congressman Hyde learned that elective abortions were being funded for American Indians and Alaska Natives through the Indian Health Service (IHS). In response to his inquiries, IHS Director Emery Johnson, M.D., replied that while funding abortions was not specifically authorized by any law, the authorizing legislation for the IHS did permit expenditure of appropriated funds for the "relief of distress and conservation of health" of Indians. "All current requirements having been met, and procedures followed," he wrote, "we would have no basis for refusing to pay for abortions" (Letter to Rep. Henry Hyde, July 30, 1979). He added that IHS services were funded through a separate Department of the Interior appropriations bill, which had no provision like the Hyde amendment. The Reagan Administration later attempted to place an administrative restraint on this practice in 1982; Congress finally enacted legislative language as part of the IHS reauthorization bill in 1988, but even this language only references whatever policy the Hyde amendment places on HHS funds in a given year.

[7] *Planned Parenthood* v. *Casey*, 505 U.S. 833, 877 (1992) (emphasis added).

[8] *Gonzales* v. *Carhart*, 550 U.S. 124, 158 (2007) (emphasis added).

- In 1997, it was discovered that some states were using federal Medicaid funds not to reimburse directly for particular services, but to help pay premiums for overall benefits packages or capitation fees for health maintenance organizations (HMOs). Since the Hyde amendment only prohibited expending federal funds for abortion itself, some thought states might be free to subsidize elective abortions by using federal funds to help purchase overall health plans that cover abortion. A second sentence had to be added to the Hyde amendment, to forbid using federal funds for "health benefits coverage that includes coverage of abortion." This same policy, denying federal funds to any health plan that covers elective abortion, was also incorporated into the State Children's Health Insurance Program (SCHIP) and the Federal Employees Health Benefits Program (FEHBP), creating a consistent federal policy: Wherever federal and nonfederal funds are combined to purchase a health benefits package, no part of that package may cover elective abortions. That policy was consistently applied until 2010, when it was contradicted by the final version of what is now known as the Affordable Care Act (ACA).

- In 1998, Congress became aware that Medicare was subsidizing abortions for non-elderly enrollees who were eligible for Medicare due to disability. Because federal funds appropriated through the Labor/HHS appropriations bill are combined with other funds such as premium payments and co-pays in the Medicare trust fund, which then reimburses for medical services, some federal officials thought they could fund these abortions while claiming this was not a use of federally appropriated funds. After congressional inquiries, HHS Secretary Donna Shalala reversed this interpretation and said that Medicare would follow the Hyde criteria (Letter to Senate Assistant Majority Leader Don Nickles, June 22, 1998). This policy, that a trust fund receiving federal funds may not be used to help fund abortions (or to help fund a health plan that covers abortions), was incorporated into the Hyde amendment for Fiscal Year 1999 and has remained in effect ever since.

- The absence of a government-wide law against federal funding of abortion led most recently to the passage of major health care reform legislation that contains at least *four* different policies on this issue. Section 1303 of the ACA, on health plans in state exchanges, complies with the first sentence of Hyde (against direct and traceable funding of abortion procedures themselves) but violates Hyde's second sentence (against funding health plans that cover abortions). Section 1101, on state high-risk insurance pools, appropriates its own new funds outside the bounds of the Hyde amendment, and allows those funds to be used for abortions or not, depending on a changeable decision by the Secretary of Health and Human Services. Section 10503, on community health centers, omits any reference to Hyde, and allows its new funding to be governed by underlying mandates in the authorizing legislation for these centers – mandates that in other health programs have been interpreted by federal courts to *require* federal funding of abortion, whenever that presumption is not corrected by explicit Hyde language. Finally, Section 4101, on school-based clinics, explicitly excludes abortion funding. All except

the last of these disparate policies are incompatible with the Hyde amendment and similar longstanding federal policies; each of them is incompatible with all the others.[9]

Three Recent Developments Highlighting Problems in the Affordable Care Act

Three specific developments since the enactment of the ACA highlight some ways in which it allows expanded federal support for abortion, if not corrected by later legislation.

First, in July 2010, a few months after enactment of the ACA, it was discovered that HHS had approved federally funded coverage for elective abortions in several states, under Section 1101's provision for state "high risk pools." This is a temporary program, providing coverage to those who have been unable to purchase it because they have preexisting conditions; it was intended to lapse once the state insurance exchanges become active. Each state was to develop its list of benefits and other details; the federal government would approve these plans and provide all public subsidies for the coverage. Pro-life groups found that HHS had already approved plans in some states that covered elective abortions; at least one state was already enrolling people in the plan.[10] In response to public criticism, HHS belatedly issued new guidance stating that these plans would not cover abortion except under the rare circumstances allowed by the Hyde amendment. But an Administration spokesperson announced that this decision "is not a precedent for other programs or policies given the unique, temporary nature of the program..."[11] The Congressional Research Service later concluded that this program was not covered by the Hyde amendment, and that nothing in the Act itself, or in President Obama's contemporaneous executive order on abortion funding, authorized HHS to exclude elective abortions even from this program.[12] The Secretary of HHS could arguably exclude them in this specific case, only because this particular section of the Act explicitly required the high-risk pools to comply with

[9] For more about this and other problems in the final version of the ACA see www.usccb.org/healthcare. The United States Conference of Catholic Bishops has declined advocating for or against repeal of the ACA since its enactment, focusing instead on advocating changes to address the bishops' key priorities of universal access to affordable care, respect for life and conscience, and fairness to immigrants. See USCCB News Release, "Bishops Note Way Forward With Health Care, Clarify Misconceptions," May 21, 2010, at http://old.usccb.org/comm/archives/2010/10-104.shtml.

[10] Pennsylvania's plan stated that it would not cover "elective abortions" -- but would cover any abortion that was not illegal under state law, which amounted to the same thing. See Brooks Jackson, "Taxpayer-funded Abortions in High Risk Pools," *Fact Check*, at http://www.factcheck.org/2010/07/taxpayer-funded-abortions-in-high-risk-pools/.

[11] See National Right to Life Committee News Release, "NRLC: This shows the law allows abortion funding," July 29, 2010, at https://www.nrlc.org/communications/releases/2010/release072910/.

[12] For a more complete analysis of the executive order's failure to address abortion problems in the ACA, see USCCB Office of the General Counsel, "Legal Analysis of the Provisions of the Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection," March 25, 2010, at http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-care-memo-re-executive-order-final-2010-03-25-pdf-09-03-48.pdf.

"any other requirements determined appropriate by the Secretary."[13] The chairman of the U.S. bishops' Committee on Pro-Life Activities welcomed HHS's final decision in this case, while expressing grave concern that federal funding for elective abortions had come so close to being implemented. "This situation illustrates once again the need for Congress to enact legislation clearly stating once and for all that funds appropriated by PPACA will not pay for abortions or for insurance coverage that includes abortion," he said. "In this program as in others, the issue of government involvement in the taking of innocent human life should not remain subject to the changeable discretion of executive officials or depend on the continued vigilance of pro-life advocates."[14]

Second, as the state exchanges for purchasing individual health plans have begun to be implemented, Americans have become more aware of the strange and unprecedented abortion policy that will govern these plans (wherever state law has not intervened to establish a different policy). Each insurance company will decide whether its plan will include elective abortions, for those who receive federal subsidies as well as those who do not; once that decision is made, federal law will demand that *every* enrollee must help pay for those abortions, notwithstanding any conscientious objection they may have; this mandatory surcharge for abortion will be kept in a separate account from the account used for federal premium subsidies, apparently so it can be said that no "federal tax dollars" are being used for elective abortions; and insurers are forbidden by federal law to make any special effort to inform people that their plan includes such abortions, or to tell them how much they will be paying for other enrollees' abortions.[15]

This "separation of funds" scheme is contrary to the policy of the Hyde amendment and parallel laws, which forbid federal subsidies to any part of a benefits package that includes elective abortions. It also violates the spirit of these laws in terms of subsidies for abortion itself. If I find myself explicitly forced by federal law to pay for other people's abortions, as a condition for receiving the health care my family and I need, is it really that important to me whether the law calls the forced payment a "premium" rather than a "tax"?

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[13] This requirement, not found in other parts of the ACA that raise the issue of abortion funding, is at Sec. 1101 (c)(2)(D) of the Act. See Congressional Research Service, "High Risk Pools Under PPACA and the Coverage of Elective Abortion Services," July 23, 2010, at www.nrlc.org/uploads/ahc/CRSReportAbortionandHighRiskPools.pdf.

[14] USCCB News Release, "Pro-Life Chair Welcomes HHS Exclusion of Abortion from Federal Insurance Program, Calls For Permanent Law," July 15, 2010. http://www.usccb.org/news/archived.cfm?releaseNumber=10-142.

[15] For a detailed analysis see USCCB Secretariat of Pro-Life Activities, "Backgrounder: The New Federal Regulation on Coerced Abortion Payments," November 6, 2013, at http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Backgrounder-The-New-Federal-Regulation-on-Coerced-Abortion-Payments.pdf. The secrecy provisions in this part of the ACA haves prompted the introduction of a separate federal bill which the U.S. bishops support, the "Abortion Insurance Full Disclosure Act" (H.R. 3279, S. 1848).

Some may answer that enrollees can choose a health plan whose provider has chosen to exclude elective abortions. However, the option to do so may be very limited or non-existent for some Americans. The ACA requires that at least one "multi-state plan" offered across state lines must exclude elective abortions; however, that plan need not be offered in all 50 states until 2017. In some states it seems *every* plan in their exchange will include elective abortions.[16] In these states, Americans who are conscientiously opposed to paying for the destruction of unborn human life through their individual health plans will be forced by the federal government to violate their conscience, or forgo health coverage altogether (and pay a federal penalty for remaining uninsured).

Third, the ACA has had the effect of expanding abortion coverage (and greatly narrowing freedom of conscience on abortion) by requiring members and key staff of Congress to transfer from the Federal Employees Health Benefits Program (FEHBP) to the state exchanges. All plans in the FEHBP, of course, are federally subsidized and made available by a federal agency, so all have long excluded elective abortions. By contrast, members and staff in Washington D.C. have been forced to seek coverage on the D.C. exchange, where only 9 out of 112 plans exclude such abortions.[17] By nonetheless issuing a rule to maintain the subsidies authorized by the FEHBP for these federal employees, the Administration has effectively nullified the longstanding appropriations rider that forbids use of federal funds for such abortions or "to pay for… the administrative expenses in connection with any health plan… which provides any benefits or coverage for abortions" beyond the exceptions allowed by the Hyde amendment.[18]

The Benefits of a Clear and Consistent Federal Abortion Funding Policy

Obviously the current patchwork of almost a dozen legislative provisions, most of which must be reapproved each fiscal year, has not always adequately served the will of Congress or the American people in preventing all forms of federal subsidy for abortion. However, at least until 2010, Congress has always acted to address the immediate problem once it has understood that problem and had an opportunity to address it. It should do no less today. In fact, it should finally put a stop to this ungainly mechanism and simply apply the principle of the Hyde

[16] This seems to be true at least in Connecticut and Rhode Island. See C. Donovan and G. Plaster, "Abortion in the Obamacare Exchanges," *National Review Online*, December 4, 2013, at http://www.nationalreview.com/corner/365504/abortion-obamacare-exchanges-chuck-donovan-genevieve-c-plaster.

[17] See Rep. Chris Smith, "Only 9 Plans Exclude Elective Abortion" (using information from DC Health Link), at http://chrissmith.house.gov/uploadedfiles/2013_12-02_floor_flyer_on_member_hc_plans.pdf.

[18] See: USCCB News Release, "USCCB Urges Office of Personnel Management to Comply With Federal Ban on Funding Health Plans That Cover Abortion," September 4, 2013, at http://www.usccb.org/news/2013/13-158.cfm; National Right to Life Committee News Release, "National Right to Life Blasts Obama Administration's Final Rule, Charging that the Government is 'Falsifying' what the Law Says," October 1, 2013, at http://www.nrlc.org/communications/releases/2013/release100113/.

amendment across the federal government once and for all.

If a bill like H.R. 7 had been enacted before the health care reform debate began, that debate would not have been about abortion funding. A major obstacle to support by Catholics and other pro-life Americans would have been removed, and the final legislation would not have been so badly compromised by provisions that place unborn human lives at grave risk.

The USCCB has also supported the Protect Life Act (H.R. 358 in the 112th Congress), to address these and other abortion-related problems in the ACA itself.[19] The benefit of H.R. 7, however, is that it would prevent problems and confusions on abortion funding in future legislation. Federal health bills could be debated in terms of their ability to promote the goal of universal health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly "health care" at all. Annual funding bills could be discussed in terms of how their budget priorities best serve the common good, instead of being endangered because some want to use them to reverse or weaken longstanding federal policy on abortion funding. This is a result that everyone in Congress should welcome.

Answering Questions About H.R. 7

A number of questions have been raised about H.R. 7, sometimes in the form of charges by groups committed to government support for abortion. These groups have abandoned their earlier slogan of "choice" and instead are committed to "access" – which means maximizing abortions, and using the coercive power of government to enlist the unwilling aid of taxpayers and health care providers who disagree with them. Answers are offered here for some of these questions.

Does H.R. 7 eliminate private coverage for abortion, or forbid people to spend their own money on such coverage?

No. In fact, Sections 304 and 305 of Title I explicitly allow such coverage to be purchased and provided as long as it does not use federal subsidies. Those who want abortion coverage can use nonfederal money to purchase a plan that includes it; or they can receive a federal subsidy to purchase a plan that does not include it, and buy abortion coverage separately with nonfederal funds.

Critics claim that such separate abortion riders will not be offered or will be difficult to obtain. The experience in states that have generally prohibited abortion coverage except by optional rider rebuts this claim. Supplemental abortion coverage is available in these states – in some plans offered by large insurers, choosing this coverage requires a simple check-off. The

[19] H.R. 358 was approved by the full House 251-172 on October 13, 2011, but was not considered by the Senate.

problem is that almost no woman chooses abortion coverage, which is to be expected in light of the surveys showing that most women oppose it. Abortion coverage is included in so many plans now because it is imposed on women and men by employers and insurance companies without their consent and generally without their knowledge. (In the ICR poll cited earlier, 68% of those who had insurance simply *did not know* whether their plan covered abortion, though that same percentage would reject such coverage if the decision were up to them.)

What this legislation does is place abortion coverage more in the arena of *individual choice* for women – an outcome opposed by groups that once claimed to be "pro-choice" and "pro-woman." They prefer a status quo in which insurance companies or employers choose abortion coverage and impose it on others, chiefly because it is cheaper for them than reimbursing for live birth.[20]

A more limited and subtle argument has been advanced by Prof. Sara Rosenbaum and colleagues at George Washington University.[21] They point out that the policy outlined here – denial of federal subsidies for health plans that include elective abortions – already affects many millions of people under Medicaid, the Federal Employees' Health Benefits Program, SCHIP and so on. By extending this policy to millions more (*e.g.*, to middle-income people who purchase their coverage on state exchanges), the new legislation when combined with existing laws may produce a "tipping point" where coverage without abortion becomes the usual norm for health insurance; coverage that includes abortion will be permitted but rare.

My response to this prediction is that I hope it is correct. As the Supreme Court noted approvingly three decades ago, the purpose of a federal funding ban is precisely to use the government's funding power to encourage childbirth over abortion. Abortion coverage, and therefore abortion, may become more rare, a result favored by all but the most committed advocates for abortion.

It is well established that providing federal funds for abortions substantially increases abortion rates. In one study by the Guttmacher Institute, for example, Medicaid-eligible women whose states provide Medicaid funding for abortion have more than *twice* the abortion rate of eligible women whose states do not provide such funding.[22] At the same time, with or without

[20] John Nugent, CEO of Planned Parenthood of Maryland, says of abortion coverage that "the insurance companies think they should be offering it" because it's "cheaper to terminate an unwanted pregnancy rather than taking it to term." David Whelan, "Obamacare: Why Private Insurers Like Paying for Abortion," *Forbes* Blog, January 7, 2010, at http://blogs.forbes.com/sciencebiz/2010/01/07/obamacare-why-private-insurers-like-paying-for-abortion/.

[21] Sara Rosenbaum *et al.*, "An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions," The George Washington University Medical Center, November 16, 2009, at http://sphhs.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.

[22] "In states that provide Medicaid funding for medically necessary abortions, women with Medicaid coverage had

federal subsidies, some private insurance companies will most likely continue to cover elective abortions because they see it as cheaper to dispose of a child than to help provide health care for him or her. It is difficult to rebut that claim in its own crass terms. In the short run, at least, live people do cost more to take care of than dead ones. Therefore, as long as abortion is legal, insurers and others ruled by a profit motive will have an economic incentive to promote abortion over childbirth. At the very least, a federal policy against subsidizing elective abortions is needed to counter that bias.

Does Title II of H.R. 7 create an unprecedented policy of denying "tax benefits" to abortion?

No, that issue was settled by the ACA. Members of Congress discussed whether the premium tax credits that help make health coverage affordable on state exchanges constitute federal funding, and decided in the affirmative. The provision forbidding direct use of these credits for abortion is even titled "Prohibition on the Use of Federal Funds" (Sec. 1303 (b)(2)).[23]

The ACA debate drew attention to the issue of how our tax system treats abortion, and uncovered some remarkable facts. For example, the individual tax deduction for medical expenses can be directly used to help reduce the cost of an abortion performed for *any* reason (not just abortion coverage but payments for abortions themselves).[24] This seems a very explicit and direct statement that the government wants to help pay for your elective abortions. Now that this loophole allowing tax support for abortion has been discovered, H.R. 7 is addressing it.

Conclusion

H.R. 7 is a well-crafted and reasonable measure to maintain longstanding and widely supported policies against active government promotion of abortion. It consistently applies to all branches of the federal government the principle that government can encourage childbirth over abortion through its funding power. It merits prompt and overwhelming support by this Congress.

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an abortion rate more than four times as high as women without such coverage (89 vs. 21 per 1,000). In contrast, in states that do not cover abortion services for women on Medicaid, the abortion rate among Medicaid recipients was twice that of women without Medicaid coverage (35 vs. 16 per 1,000)." Rachel Jones et al., "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health*, vol. 34 (2002), 226-235 at 231. See www.guttmacher.org/pubs/journals/3422602.pdf.

[23] This provision still violates the policy of the Hyde amendment by allowing use of these credits to purchase overall health plans that cover abortion. But it did establish the idea that abortions not eligible for federal funding under Hyde should be ineligible for these advanceable, refundable tax credits.

[24] "You can include in medical expenses the amount you pay for a legal abortion." Internal Revenue Service, Publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, Dec. 9, 2008, page 5.

Mr. FRANKS. We will now go into the time for questions. And I would thank each of the witnesses for their testimony. And we will proceed under the 5-minute rule. And I will begin recognizing myself for 5 minutes.

Ms. Alvaré, I would note that Mr. Doerflinger quoted Harris versus McRae in the court. And the court said, "No other procedure involves the purposeful termination of a potential life." And affirmed that Roe versus Wade had created a limitation on government, not a government entitlement. Three years earlier, the Supreme Court had ruled that the government's refusal to fund abortion placed no restriction on the "right to choose abortion."

Your testimony was especially compelling when you mentioned about women's attitudes toward abortion in the coming days. And my friends on the left, oftentimes when they are faced with an indefensible position try to change the issue to something else entirely. And it is very difficult then to debate the issue in any effective way.

Can you tell me how both of those stated concerns coincide with H.R. 7, in your opinion?

Ms. ALVARÉ. If I could clarify, the stated concerns regarding what is said in Harris versus McRae?

Mr. FRANKS. The court's decision and also women's attitudes toward abortion.

Ms. ALVARÉ. Yes. I mean, the court's decision is very clear. It's established as a matter of law. But I think it also seems as a matter of common sense to many people in the United States that refusing to fund something is not a statement that the government has done away with what is still in this country a constitutional right, and the court just drew that line very clearly. It's mystifying to me sometimes when people make this argument; from the common sense perspective, it seems as if they're saying that somehow 1.2 million abortions a year isn't enough. That in order really for us to say we have some robust right of abortion, we have to have an even higher rate than 3,300 abortions a day. We already know that poor women are getting a disproportionate number of these, and that they disfavor abortion more than the well off. Right? We also have minority and immigrant women disfavoring it more than majority American women.

And so the idea that it is an interference is problematic. The other statement that comes to mind in connection with this is, you know, if you look at Planned Parenthood, the largest abortion provider's most recent balance sheet, I mean, in addition to the giant amount of government funds they have, they have $500 million a year of nongovernmental funding. If it's so important to them that there be more abortions among the poorest women in the United States, I would wonder why they don't follow the example of the over 3,000 crisis pregnancy centers who are contributing private funding to women, about $25,000 per woman per year in the residential facilities, and there are over 350 of those. So that entire argument that somehow a right has to equal funding it and the funding has to come from the government, it is neither legally supported, nor is it supported in common sense, nor would poor women in particular support that.

Mr. FRANKS. Yes, ma'am.

Thank you very much.

Mr. Doerflinger, I know some States have made their own decision on what to do about abortion coverage on their exchanges. Can you give us an update on what has happened in that regard?

Mr. DOERFLINGER. Yes, Mr. Chairman. Since the Affordable Care Act passed, 24 States have acted to opt out of the abortion policy on the State exchanges set out by the Federal Government, the presumptive policy in which Federal funds are used to subsidize plans that cover elective abortions. Then there's a little bit of separate bookkeeping, separate accounting for the funds used for abortion. But everybody in those plans is forced to pay that surcharge for abortion. States have looked at that policy and said, no, we're going to take elective abortions off the exchange altogether in our State. And that policy goes farther than H.R. 7, which only removes elective abortion from plans receiving the Federal subsidies.

Now, of the 13 Members of this Subcommittee, 10 of you are from States that have made that decision to simply take abortion off the exchanges, and four of the five Democrats on this Subcommittee, are from States that have made that decision. You passed the bill with this abortion policy, and your own States have said no. That's the trend now. In fact, more States than ever have taken this opportunity to actually reach out and say that abortion will not be available in private plans off the exchanges—except, in most cases by supplemental riders. Ten States have done that.

So the trend out there in the country is that about half the States now have said, no, we want a firmer policy against abortion on these State exchanges.

Mr. FRANKS. I thank the gentleman. And I will now recognize Mr. Nadler for his 5 minutes of questioning.

Mr. NADLER. Thank you. Professor Wood, the Affordable Care Act requires participating insurance plans to segregate monies for abortion services from all other funds, a measure my anti-choice colleagues insist was necessary to prevent Federal funding of abortion. To aid in identifying these funds, both in terms of premiums being paid for coverage and costs for services provided, the law requires companies to estimate the cost of abortion coverage at no less than $1 a month. Some have characterized this segregation of funds as an abortion surcharge. Is this an accurate description?

Ms. WOOD. The short answer to that question is no. As you have correctly stated, this is a general premium to provide for all health care services. And because of the Nelson Amendment to—it both avoids use of Federal funds primarily to avoid the use of Federal funds, the segregation of the private dollar contribution of at least $1 a month is to be set aside to pay directly for those services. And indeed, there are accounting responsibilities of the insurers to make sure that they can demonstrate to their State insurance commissioners that they have indeed complied with the statute.

So I think in this case, it's clearly not a surcharge. It's a segregation of the premium. And women who or family plans who choose not to have a plan that does not provide abortion coverage, the option to purchase that is available to them.

Mr. NADLER. You mean that plans that choose not to have a plan that covers abortion, don't you?

Ms. WOOD. I'm saying aside from the plans that cover abortion, there will be plans available to choose if that is such an important issue.

Mr. NADLER. So it would be inaccurate to claim that an individual that objects to abortion will be forced to participate in or pay for a plan that covers abortion, or as Mr. Doerflinger put it, to subsidize someone else's abortion?

Ms. WOOD. That is correct.

Mr. NADLER. And that would be inaccurate because?

Ms. WOOD. That is because plans in the statute, it does call—though there is no requirement to cover abortion, sort of in a balancing way, there is a requirement that there be plans available that do not cover abortion that an individual can choose. And, indeed, that information about coverage of abortion must be made available through the summary of benefits that would be provided upon purchase.

Mr. NADLER. Okay. So now tell me, how common is it now for insurance plans to cover abortion services now, and how would that change if H.R. 7 is enacted?

Ms. WOOD. I think this is the crux of the matter. Since the beginning when people have been measuring this, abortion has been covered. And I think it is important——

Mr. NADLER. Has been covered by private insurance.

Ms. WOOD. Has been covered by private insurance. Absolutely. And because it has sort of been—and it has not been called out or controversial. It has been part of the general medical and surgical benefits that are covered as needed by any individual. And it is important to remember that insurance is set up just as that. It is for those anticipated and unanticipated things that can happen in your life. We will all need health care at some point. We may not know what it is. Maternity care hopefully is planned anticipated coverage.

Mr. NADLER. So that has always been included. How would that change if H.R. 7 is enacted?

Ms. WOOD. Okay, sorry. Yes, it would change dramatically, I think, and this is the analysis we did just in looking at the Stupak amendment, but we think it applies also even more so to H.R. 7, which is it will create a change in the insurance market because if insurers have to tease out not an entire class of benefit, but specific procedures under specific circumstances, they will likely, over time, begin to decide that this is not worth the effort, it is not worth the——

Mr. NADLER. So in other words, this bill would have the effect of getting private insurance companies that now offer coverage to not do so?

Ms. WOOD. We project that eventually would change, and we have used the word tipping point. That historically plans have covered abortion under medical health insurance, and now it will tip to the norm being non-coverage.

Mr. NADLER. And I would assume that that is really the point of the bill.

Ms. WOOD. Right. And the concern would be regulations that might be issued by the IRS, having to document, et cetera.

Mr. NADLER. So last year we had concerns given the unprecedented tax provisions in the bill that this could require some pretty invasive regulatory enforcement procedures for women who are pregnant as a result of rape or incest and for women whose lives are endangered if they continue pregnancy. Is this a concern?

Ms. WOOD. Absolutely. Having to make that determination is not something that either the IRS, insurance companies or Congress should really be involved in.

Mr. NADLER. And setting aside the privacy concerns, how might uncertainty over how an expense might be treated by the IRS impact women and how might it impact insurers?

Ms. WOOD. Well, I think impacting women, to have to document a rape or a condition of incest is traumatic at the minimum. I think in terms of insurers, they do not want to be in the place of having to make a determination of which is an acceptable exception to the ban on coverage, or whether it needs to be covered by either the woman herself or by this potential rider that would then need to be coordinated with the base plan.

This raises a lot of regulatory and oversight and implementation concerns that insurers have traditionally never been involved in and would—in their traditional way would be to just cut out that entire set of coverage entirely and not want to go into making those determination, leaving all abortions uncovered.

Mr. NADLER. My time has expired. I thank you.

Mr. FRANKS. We will now recognize the gentleman from Ohio, Mr. Chabot, for 5 minutes.

Mr. CHABOT. Thank you, Mr. Chairman. Mr. Doerflinger, let me begin with you, if I can. Can you explain the stance that the Catholic Bishops Conference took on the Affordable Care Act and why that organization ended up opposing final passage of the bill?

Mr. DOERFLINGER. Yes, sir. The bishops have been in favor of government involvement in ensuring people's access to health coverage since 1919, when they made a statement after World War I about social reconstruction. We were very much in favor of pursuing health care reform, and we put out a great many materials saying basically that we hope Congress will address this problem, we want to move to universal health coverage, but there are moral principles that that should respect.

The coverage should be affordable and fair, it should extend to everyone— and in that respect, the final bill, in our view, and I know I will disagree with some of the majority Members of this Committee on this, we felt it should fully cover immigrants, regardless of their legal status. We felt it should respect the existing longstanding policies in all of these other programs, that Federal funds do not get used for abortion or any part of a health plan that covers abortion. That is current law now in the Hyde Amendment, in Federal Employees Health Insurance, in the SCHIP program. And, thirdly, we felt that it should have strong protections for rights of conscience, which of course, it does not, as witness two cases that are going up to the Supreme Court now.

So in the end, we were very encouraged by the House bill. The Stupak amendment was approved with the support of 64 Democrats, including House Appropriations Committee Chair David Obey. We had a bipartisan agreement that we are going to set this

abortion issue aside and talk about health care. And then the Senate changed it back.

I don't know why we are talking about a Nelson amendment. I think Mr. Nelson convinced Harry Reid to put in some additional accounting procedures, but what is in the bill now is basically the Lois Capps amendment that was prepared by——

Mr. CHABOT. Let me stop you there, if I can, just because we have got limited time. Despite claims from the Administration that the Affordable Care Act abides by the principles of the Hyde amendment, we know that health care, Federal tax subsidies are paying for health care plans, or will, including elective abortions.

Is it your belief that additional tax subsidies like this to individuals to pay for health care plans which could have elective abortions will, in all likelihood, increase the number of abortions performed in this country?

Mr. DOERFLINGER. Of course. You know, Dr. Wood said that most plans have abortion, and that is true, but that is not because people want it. Sixty-eight percent of women, in the last poll we did on this, are against having abortion in their coverage. And so those decisions are being made largely by the for-profit insurance companies because abortion is cheaper than a live baby. Wow. Imagine that. Live babies are more expensive than dead ones. So the insurance companies have an economic incentive to promote abortion coverage and they include it.

Mr. CHABOT. Let me cut you off there if I can at this time.

Mr. DOERFLINGER. But what this bill says is we are not going to put Federal funds into encouraging that bias.

Mr. CHABOT. Thank you. Ms. Wood, let me turn to you real quickly. Why did President Obama issue his executive order which purported to curb abortion funding or stop funding?

Ms. WOOD. I think it is clear that the Affordable Care Act already through the Nelson amendment ensures that no Federal dollars are going toward abortion. And that certainly is a conversation we can have about, you know, my opinion that those bans are not appropriate, but that that is, in fact, what is in the Affordable Care Act. And his memo merely confirmed what was already in the statute.

Mr. CHABOT. Thank you. Ms. Alvaré, let me turn to you if I can here. You had stated in your testimony that, and I am putting this in my words, you said that women really don't support abortion overall, even though we sort of think politicians think that, the press kind of says women are for it and men are against it, you know. Would you clarify that a little bit?

Ms. ALVARÉ. Yes. The best study I have seen on this with really great cross-tabs, very detailed on women at every income level, women of different racial and educational background, was the RAND Corporation in cooperation, I think it was with the Packard Foundation, Rockefeller Foundation. You know, these are groups that are supportive of population control policies generally, including often abortion.

But what you see, and you see this in not only the quantitative but also the qualitative studies of poor women, the best book ever on this, Promises I Can Keep, Why Poor Women Put Motherhood Before Marriage, that there is this disapproval particularly among

poor women, of abortion, just a moral disapproval of it and a desire that it not be normalized or encouraged. If you look at the ratio of unintended or out-of-wedlock births among the poor, they abort a lower ratio of those than do people who are better off.

So not only is it that women are not supportive of this. I mean, this is a top-down sort of groups claiming to represent women sort of proposal. It is a political thing, it is not a health care thing, and it certainly does not speak for grassroots women, particularly poor women in America.

Mr. CHABOT. Thank you very much. I yield back, Mr. Chairman.

Mr. FRANKS. I thank the gentleman. I now recognize Mr. Cohen for 5 minutes.

Mr. COHEN. Thank you, Mr. Chair.

Ms. Alvaré, let me ask you a question. Do you believe this bill, H.R. 7, would include birth control in making it illegal?

Ms. ALVARÉ. No. My understanding is that it addresses abortion.

Mr. COHEN. Only abortion. Okay. Let me ask you this too. Does this bill ban a State like Arizona from spending its local funds on abortion?

Ms. ALVARÉ. It is my understanding that if a State wants to spend its own money on abortion, that a State can do that. States already do that.

Mr. COHEN. So it doesn't ban a State like Arizona from doing that, or Arizona hospitals from performing abortions. It doesn't ban that either?

Ms. ALVARÉ. The question in this bill is taking Federal funds out of it. If you are really—you have to be speaking, and I am sure a particular hospital, a particular locale would be able to give you, sort of an Arizona expert would be able to give you statements about whether their hospitals, their locales, et cetera, how or how much or in what way they interact with Federal funding. But, again, the purpose of this is to draw the lines between Federal funding for abortion——

Mr. COHEN. How about D.C.? Would it affect D.C. hospitals and D.C. from spending its local funds on abortion?

Ms. ALVARÉ. It is my understanding because of the definition of D.C. for the purposes of this bill and obviously in connection with a longstanding relationship between the Federal Government and D.C., that, yes, it would prevent D.C. from spending money that it wished to spend, which is a good thing.

Mr. COHEN. I know you were not a Member of Congress and you weren't here during the Republican shutdown, but during that shutdown, the Republicans almost were unanimous in favor of letting D.C. spend its local funds, even during the shutdown. So there seemed to be kind of a bright chink in the armor of D.C. being a Federal——

Ms. ALVARÉ. I am not actually political on these question. I try to take a principled or a legal or empirical view. I am not about recognizing the political——

Mr. COHEN. Let me ask you a question. You mentioned a lot of polls about lower income people and pro-life——

Ms. ALVARÉ. I am sorry, I couldn't hear you, sir.

Mr. COHEN. You mentioned a lot of polls about low income people and their positions on pro-life.

Ms. ALVARÉ. On abortion and abortion funding.

Mr. COHEN. And that most low income people you said, poor people, were pro-life. And you talked about pro-life and the Federal Government, and because it was death and it was gruesome and it was ugly and all those things. Most polls, and there are more polls that I can name, show that most pro-life people, women, are also in favor of the death penalty. How do you reconcile that, because that type of death is gruesome?

Ms. ALVARÉ. Two things. Number one, I could not personally or principally reconcile it myself and that is why I have been publicly on record against any Federal support for killing, whether it is the death penalty or abortion.

Mr. COHEN. How about war? How are you on war?

Ms. ALVARÉ. Number two, I guess I haven't written anything on it outright. Because of my background, which is an overlap of both philosophy, theology and law in the area, I am—I guess you would say my general position would be, in case this matters to you or would help shape your opinion on the bill, I am not sure how it relates to anyone else's opinion around here, I am in favor of life. And in my knowledge of the church, its just war theory in particular, which I think is a very good outline of the theory, would probably be an explanation of my position, if that is influential to you. I hope it would be.

Mr. COHEN. Right. Just for time limits. Mr., is it——

Mr. DOERFLINGER. Doerflinger.

Mr. COHEN. Doerflinger. You work for the church, is that correct, for the bishops?

Mr. DOERFLINGER. That is correct.

Mr. COHEN. And Ms. Alvaré is a consultant. Now, the Pope has been real good on saying that these issues concerning gays and abortion are part of the Catholic history, but that they should be kind of lessened in terms of the real big issues, which is the great disparity in wealth between the wealthy and the poor, and we need to do more things about taking care.

I wonder what you or either of you all are doing to try to influence my colleagues to do things about unemployment insurance, to do things about food stamps support and Meals on Wheels and things like that, and maybe tax policy that kind of levels the playing field out so you can do the Pope's work here in the United States Congress? I am a big fan of the Pope's new positions. I am just wondering what you were doing to move those forward.

Mr. DOERFLINGER. I have to begin by differing with you on the interpretation of what Pope Francis has said, because what he has said is that all of these issues are important, but it is better to put them in a deeper context as a consistent message about the dignity of all human beings than to treat them as individual political positions. What he said about abortion is that——

Mr. COHEN. Let me ask first, what did he say about the disparity in wealth?

Mr. DOERFLINGER. He said there is a huge problem in the disparity of wealth. And I would say this. Yesterday was the 50th anniversary of President Johnson's announcement of the War on Poverty. That is an issue that is very close to the bishops' hearts. The bishops just yesterday sent up a letter encouraging Congress to in-

crease the minimum wage. We are celebrating Poverty Awareness Month—January is Poverty Awareness Month—by educating Catholics about the need to fight poverty. Our Catholic Charities, our Campaign for Human Development, our Catholic Relief Services are out there providing help to millions of people in poverty, and I think doing—no offense intended—doing so more effectively than many government programs do.

We are very much in favor of the War on Poverty. But we also insist, and so does Pope Francis, that the War on Poverty must never become a war on the children of the poor. Pope Francis has said it is not progressive to try to solve our problems by eliminating a human life.

Mr. FRANKS. The gentleman's time has expired.

Mr. CHABOT. Mr. Chairman, I would ask unanimous consent that the gentleman be granted an additional 30 seconds and I would ask the gentleman to yield to me if he would.

Mr. FRANKS. Without objection.

Mr. COHEN. I don't have a problem. I yield.

Mr. CHABOT. I thank the gentleman for yielding. My only point was he was just about to say on abortion the Pope said, and then you cut him off and we never heard, and I would be interested to hear what the Pope said on abortion.

Mr. DOERFLINGER. Oh, I am sorry. Just that this dignity of life, even from the very beginning, is so intimately linked with all our other human rights, that if you take a wrong turn on that, it undermines the basis of all the other rights we are trying to fight for. That has been said by Pope John Paul II and Pope Benedict and it has been said by Pope Francis as well. He said the church is not going to change its position on this. If it changes its position on this, its whole moral logic about the dignity and rights of every human being falls down.

Mr. CHABOT. I thank the gentleman for yielding.

Mr. FRANKS. I would now recognize the gentleman from Ohio—I am sorry, the gentleman from Iowa, I am getting the folks mixed up here, Mr. King. I am sorry, we have got the list here. I recognize the gentleman from Virginia, Mr. Forbes, for 5 minutes.

Mr. FORBES. Thank you, Mr. Chairman. I want to thank all of our witnesses for being here. I know you are all incredibly good people, smart people, passionate about your issues. These are complex issues. Sometimes in these hearings, we do truly the forest for the trees when we get off on poverty, war, peace, death penalty, those kinds of things, and we have to keep trying to bring it back to something we can get our hands around.

Ms. Wood, I would just like to ask you a question if I could to try to get at that core. I had someone the other day that is a friend of mine and they showed me a small video of this new baby they were going to have that is going to be their grandchild. And it was only a few weeks old and they were just amazed at what they could see.

What do you call that? And I want to use the nomenclature you want so that I am not offensive to you. But before that entity is born, which I would call an unborn baby, but what would be the vernacular that I should use that would be appropriate?

Ms. WOOD. Depending on the stage, it would be an embryo or a fetus.

Mr. FORBES. Okay. In that embryo, and I will use that terminology because it is the one that you pick, or we could use fetus, either one, is there no procedure, no action that could be taken against that embryo, no harm committed, no matter how horrendous it might be, that you would feel should be prohibited?

Ms. WOOD. I think the key perspective we have to take here, and this is, again, one of the unknowables, is what is the circumstance of the individual woman that is trying to decide whether to become a parent, what is her circumstances, what is her health needs. And therefore, I think there is real—taking it from that thinking where I don't stand in her shoes and none of us can really know what is going on in any particular——

Mr. FORBES. And I appreciate that. I am sorry, I think my volume——

Ms. WOOD. And those decisions are made based on her health needs and that of her physician——

Mr. FORBES. And I fully understand that. I am not arguing with you. I am just saying it would be your position, as I understand it, that there would be no procedure, no action taken, no harm committed to that embryo by your definition, that would be so egregious or so bad that we would prohibit it so long as that mother or that woman said it was okay to do it. Is that a fair interpretation?

Ms. WOOD. I don't think it is a really relevant—I mean, I don't fully grasp the question, because I think it is important to say that there are—things need to be done with good medical care in the context of high quality medical care.

Mr. FORBES. But that is not where we are. Where we are at is trying to, one, get the baseline and then determine the continuum and then determine what Federal dollars can be spent on it. But as I understand your position, there is no procedure, there is nothing that we could do to that embryo, in your vernacular, as long as that mother or that lady said it was okay, there is nothing we could do that you would feel would be a bridge too far that should be prohibited?

Ms. WOOD. I think I would still say that it would be something within the determination of the woman and her health professional, and if they came up to some—and I am not a medical professional. I don't want to say what medical procedures are correct or incorrect.

Mr. FORBES. I understand. But I am just saying that as I understand you, there is no procedure, nothing, that would——

Ms. WOOD. I think you are misconstruing my testimony.

Mr. FORBES. Then please clarify that for me. Tell me what procedures you think would be too egregious to that embryo, that even if the mother or the wife said it is okay that you would think would be too far and shouldn't be allowed?

Ms. WOOD. I think if the woman is getting unsafe abortion care, that is egregious. I think there are medical procedures which are not acknowledged or shown by evidence to be safe and effective. And I think those need to be——

Mr. FORBES. But nothing as far as that embryo is concerned?

Ms. WOOD. I think you don't separate in this case the embryo and the mother. They are—the woman is in the circumstance with her health care provider to make those determinations.

Mr. FORBES. Mr. Chairman, since my time is running out, I would simply allow Mrs. Wood, if she has such procedures, such actions that could be taken to the embryo that she thinks should be prohibited, even if the mother says it is okay to do it, if she would submit those for the record. But at this point in time, through all my questioning, I have heard none. And so if the record could just state that. And then if she would like to supplement that, we would love to give her that opportunity.

With that, I yield back, Mr. Chairman.

Mr. FRANKS. Without objection, we would ask Ms. Wood to provide us with that answer.

I would now recognize Mr. Deutch for 5 minutes.

Mr. DEUTCH. Thank you, Mr. Chairman.

Mr. Chairman, I am struggling some to figure out why we are here today. As the Ranking Member pointed out earlier, Federal funds haven't been used for abortion in 30 years. Federal funds have not been used for abortion in 30 years. So if the problem that we are truly trying to solve is to keep taxpayers from footing the bills for abortions, mission accomplished. However you feel about it, mission accomplished.

But keeping taxpayer funds away from abortion isn't why we are here. Instead, this Committee, on a regular basis, seems intent on picking away at a constitutionally protected right with misleading backdoor legislation. Whatever your personal feelings about abortion, and whether you would want a woman in your family to make that choice or not, we must all recognize that that woman has a constitutionally protected choice to make about her own body. To create new restrictions on the coverage of abortion by private insurance companies in the guise of taxpayer protection I think is outrageous, and I have some questions for the witnesses that I just would like to probe.

Mr. Doerflinger, starting with you, I respect entirely your belief based on sincere and strongly held religious tenants that abortion is wrong, and I have the same respect for my colleagues, for so many of my colleagues on this Committee. But here is where we disagree. America is a multicultural society. We don't all subscribe to same religion. I don't believe that one religious view should be imposed on others, and using the massive power of the Federal Government to force others to share your religious views or penalize those who view differently is a dangerous approach. So I just would like to explore that with you, some.

If a majority in Congress had strongly held religious belief that blood transfusions were immoral, would it be appropriate for that majority to ban blood transfusions?

Mr. DOERFLINGER. We are not talking about banning anything, sir.

Mr. DEUTCH. Would that be appropriate for the majority to do that? That is the question I am asking you. We are just engaging in some hypothetical situations, Mr. Doerflinger?

Mr. DOERFLINGER. No.

Mr. DEUTCH. And what about vaccinations? Some have strongly held beliefs on the matter of vaccinations. In your view, would it similarly be permissible for a majority in this Congress to ban vaccinations?

Mr. DOERFLINGER. No.

Mr. DEUTCH. And for people who hold religious objections to alcohol and tobacco, there is insurance, maybe this one gets more at this issue that we are talking about today, there are insurance plans that provide coverage for smoking cessation and treatment of diseases borne out of alcohol and tobacco use. If a majority of this Congress felt that there is no reason taxpayer dollars should be used to support treating disease borne out of alcohol addiction, should we be able to take that action akin to what this legislation does with respect to abortion?

Mr. DOERFLINGER. No, nor should the government force people to fund those addictions.

Mr. DEUTCH. And let me just go on because I have a few more and only limited time. I am sorry.

Mr. DOERFLINGER. But this is all irrelevant to the bill at hand.

Mr. DEUTCH. It is not irrelevant. Ultimately, sir——

Mr. DOERFLINGER. You are making a fundamental——

Mr. DEUTCH. No, no, let me explain my own position, which I thought I had already done but I will do it again. The suggestion in this bill, what this legislation does is despite the argument that we are protecting people from the Federal Government, it says that the massive power of the Federal Government can be used to shut down a constitutionally protected right.

Mr. DOERFLINGER. That is absolutely false.

Mr. DEUTCH. That is what this legislation does.

Mr. DOERFLINGER. Have you read the bill, sir?

Mr. DEUTCH. I had, indeed, read the bill, Mr. Doerflinger.

Mr. DOERFLINGER. Section 304 says you are wrong.

Mr. DEUTCH. I appreciate your asking. And the other thing that is so troubling to me, I have one more question, it is on the same topic, just to finish out the list, embryonic stem cell research. Now, I know that embryonic stem cell research, despite its potential life-saving revelations, is controversial in some parts. Should Congress be able to impose tax penalties on people who purchase insurance policies that cover cures that were devised from embryonic stem cell research?

Mr. DOERFLINGER. There aren't going to be any cures from embryonic stem cell research, and this is not about penalizing it.

Mr. DEUTCH. Mr. Doerflinger, I don't have the time to engage in that debate, but I would respectfully suggest to you that perhaps as you have encouraged me to take another look at the book, that you might well take a look at the research that is being done right now in research centers across the country before you suggest that there will be no treatments or cures to come from embryonic stem cell research, and for all of the people, for all the advances which have been made and the people whose lives could be improved by it, I would ask you to reconsider.

And, finally, I would just suggest to Professor Alvaré that she is exactly right, exactly right, when she says that what we ought to be doing is focusing on a real women's agenda. I agree. And my

hope is, Mr. Chairman, that as we go forward in this Congress, we might focus on a women's agenda that acknowledges that women earn 70 cents on every dollar earned by men, and that minimum wage increases is a women's issues because two-thirds of minimum wage workers are women, and that if we raise the minimum wage, which is 30 lower than what it was in 1968, that we will see an immediate reduction in poverty among women, and that workers in 145 countries in the world have earned paid sick days, and the U.S. has no mandatory paid family medical leave policy. We are one of three counties in the world and the only industrialized country to not have mandated maternity leave.

This is an agenda for women that this House of Representatives ought to take up. I appreciate your making that point, Professor Alvaré, and I yield back.

Mr. FRANKS. I thank the gentleman. And just for the record, this bill does not cause the massive power of the Federal Government to force people to make any decision. It simply prevents the massive power of the Federal Government to force taxpayers to pay for the killing of innocent unborn children.

I would now recognize Mr. King for 5 minutes.

Mr. KING. Thank you, Mr. Chairman. I thank the witnesses. And I would first disagree with Mr. Deutch on the statement that the Federal Government hasn't funded abortions for 30 years, and I would ask Mr. Doerflinger if he could speak to that.

Mr. DOERFLINGER. Yes, sir. It is for 35 years that the Federal Government has been barred from using Federal funds for the vast majority of abortions. What has changed, what is new, and it is not a new effort by a cabal of mean-spirited conspirators as Dr. Wood would like to say, is that Federal funds have now moved into a vastly broader arena of the health care system. We are no longer talking about Medicaid just for the poor, we are talking about tax subsidies for the middle class—who, by the way, are presumably far more able than the poor to use their own money for abortion if they are not getting Federal funds.

Mr. KING. But I would ask you——

Mr. DOERFLINGER. Now we are beginning to get into this arena——

Mr. KING. I would take you back 30-35 years and speak to Medicaid funding of abortions for rape and incest, and funding for Planned Parenthood while we are at it.

Mr. DOERFLINGER. I am sorry, I didn't understand the question.

Mr. KING. Okay. First of all, has the Federal Government funded abortion through Medicaid funding in the cases of rape and incest over the last 30 years?

Mr. DOERFLINGER. Yes, for many years.

Mr. KING. So those would be exceptions to Mr. Deutch's statement——

Mr. DOERFLINGER. Certainly.

Mr. KING. As the Federal Government, I don't want to say "we" in this case, the Federal Government has consistently funded abortion.

Mr. DOERFLINGER. Since 1993.

Mr. KING. Under Medicaid funding for the cases of rape and incest?

Mr. DOERFLINGER. Yes.

Mr. KING. I thank you. And then we look at something like, I am pulling this number out of my head, I will say in the upper $300-plus million a year that goes into Planned Parenthood, is there a way that one could contrive, make the argument that none of that funding goes to abortion that funds Planned Parenthood?

Mr. DOERFLINGER. Well, the Title X family planning program says that none of those funds can go to a program where abortion is a method of family planning. I don't have evidence that those funds are being directed toward abortion. I think what Planned Parenthood usually does is have its Title X program on family planning done at one clinic and then that clinic refers women for abortions to another Planned Parenthood clinic that is not a Title X clinic, and it does the abortions. So there is some separation.

But even a Title X program, 1970 it dates from, put the funding ban broader than just the procedure of abortion itself: We don't want to put Federal funds into a program where these are done. So the idea that by just not funding the abortion procedure itself and taking that dollar out and switching it around, that that respects the history of American law in this area, is not true.

Mr. KING. And you wouldn't have to have a Ph.D. in money fungibility in order to figure out that $370-some million, some of that spills over into funding abortion through Planned Parenthood, even if it goes into administrative funds that in a broader perspective administer the upper side of that program.

Mr. DOERFLINGER. Well, I don't want to get into funding Planned Parenthood. I think that is a different issue.

Mr. KING. I am happy to change the subject and I thank you for your response.

Mr. DOERFLINGER. It is a little relevant. It is relevant to this extent, that by giving all this money to Planned Parenthood, we are giving money to the organization that does hundreds of thousands of abortions a year, more than any other, and I, for one, would like to see those funds devoted to organizations that are more clearly committed to the needs of women as well as their children.

Mr. KING. I agree, and I thank you. And I would turn to Ms. Wood and thinking back on your testimony, and part of your testimony was the statement to the effect that in the case of some women, abortion care costs more than their monthly rent. I have trouble calculating that equation. Could you explain that statement to the Committee?

Ms. WOOD. Yes. Particularly because of the nature of the very narrow exceptions that are allowed under H.R. 7, which is life endangerment, rape or incest, those women who have health concerns or fetal abnormalities may be facing later term abortions which can cost in the thousands of dollars.

Mr. KING. So you answer, then, would be, I think, in exceptional cases, it may cost a woman more for a single abortion than it does for her 1 month of rent check. Is that an accurate way to depict what you said?

Ms. WOOD. That is correct.

Mr. KING. Okay. I wonder how many abortions a month does she need at the going rate to keep up with the rent check?

Ms. WOOD. I do know that it pushes women into poverty.

Mr. KING. I accept your answer and I think it is fine. I want to, in the seconds I have left, speak to this issue because I have an opportunity to speak to it from the perspective of the church. And I am a Roman Catholic, I believe in good standing with the church and a faithful follower of much of the teachings. I was very concerned about the Catholic Church's involvement in the ObamaCare legislation as it moved through this Congress and the accepting of the Stupak amendment.

Here in the middle of this political arena, I believe that the church was operating in a legislative arena that they didn't quite understand; that they didn't see that there was going to be a bait-and-switch on the Stupak amendment. That is what happened. And I think the Church's desire on the principle of trying to serve people and trying to get more people covered by health insurance, the things that you talked about, Mr. Doerflinger, about the dignity of every human person, which I believe, I think they got too far ahead of themselves on this and failed to understand that abortion was going to be part of this package and that Rahm Emanuel was the person that came up with the executive order that was going to amend ObamaCare after the fact.

So I wanted to make this point in this hearing that I would ask the Church to come talk to some of us on the inside of these Chambers when these things come up and understand that we should first put the principle, it is the church's principle, of life first, and remember there is a principle of subsidiarity too. And we can serve people better many times the closer to the individuals that we can get those services than going broadly with a national policy that turns this over to a pro-abortion president.

My heart is sick at what happened with ObamaCare. The conscience protection, the litigation with the conscience protection is a result of this desire as is the abortion questions before us today. And I think if we would reassert the principle of subsidiarity, we would better protect the principle of human life.

Thank you, and I yield back.

Mr. FRANKS. I would like to thank all of the individuals for their questions——

Mr. DEUTCH. Mr. Chairman, I wonder if you could yield just 10 seconds for Mr. King to clarify that it is his position that the Federal Government through Medicaid should not spend any dollars on an abortion in the case of rape, incest or to protect the life of the mother. Is that correct?

Mr. KING. I didn't state a position.

Mr. FRANKS. So I would thank the witnesses for their answers. I would thank the Members here for their questions. I would suggest that the two most important questions asked today here is does abortion take the life of a child, and, if so, should taxpayers be forced to pay for it. And with that, without objection, all Members—I am sorry, we have been joined by Mr. Gohmert. I will now yield to him for 5 minutes.

Mr. GOHMERT. Thank you, and I appreciate the time and I appreciate the witnesses' patience. I was at another hearing. But I want to make sure that when my colleagues were bringing up the Supreme Court mandated authority to abortion, that people don't misunderstand. This hearing is not about the elimination of abortion,

but as the Supreme Court said in *Rust v. Sullivan,* that in upholding Federal limits on abortion funding, they said, "By requiring that the grantee engage in abortion-related activity separately from activity receiving Federal funding, Congress has, consistent with our teachings," which I don't appreciate teachings from the court, they are supposed to make decisions, not be teaching, especially being lectured from people that are so duplicitous at times, but separately from this Congress consistent with our teachings, "not denied it the right to engage in abortion-related activities. Congress has merely refused to fund such activities out of the public fisc."

And that is what we are talking about. And I hear people across America that have been—they have had the wool pulled over their eyes and they have been led to believe that some of us are moving laws that will end the ability to get an abortion, when actually what we are talking about here today is the right of religious beliefs, the right of conscience.

And I know all three of our witnesses, from what I have been hearing, has come over the television, you know, you are all three very sympathetic to the plight of women, and nobody is more so than I am. I have three daughters, and when my first one I held in my hands, I could have held her in one but I didn't want to risk, she was so premature, I would do anything to keep her alive. And it is hard for me to fathom someone wanting to kill what I call a child, what some may call an embryo, when she is living in my hand at the same time a child of the same age is living in someone's womb.

So I have been married for 35 years. I have three daughters. There is no war on women. But when I hear of countries around the world, and it seems to be creeping, the thought creeping into America, that we could give a woman the right to destroy a child in her womb because it happens to be a female. It is happening all over the world, China especially, babies being killed because they are a female? How long before some who support abortion with all of their heart, mind, and soul will say, wait a minute, wait a minute; the war on women has become a war on women in the womb, and at some point, at least please don't make people who see that as killing a child pay for others to kill that child. That is what we are talking about.

Legislation, we talk about Supreme Court rights, my friends across the aisle about you can't go against Supreme Court rights. The Supreme Court has said over and over and over that forcing somebody to pay, against their religious beliefs, against their heartfelt beliefs, to pay for someone else's abortion is where the problem is. So I just think that hasn't been made clearly enough from what I had been hearing.

And with regard to the Stupak amendment, Bart Stupak is my friend, I haven't seen him in a long time, but what he didn't know is what Mr. Rahm Emanuel said. "I came up with an idea for an executive order to allow the Stupak amendment not to exist in law." Mary Poppins, a fictional character that I never saw until I had kids said that is something easily made and easily broken. It is not in law. We are trying to get it in the law. And I appreciate all of you being here today. Thank you.

Mr. FRANKS. Once again, there is always tremendous intensities related to this debate, and sometimes people on both sides want to suggest that the one side doesn't care about the mother or the other side suggests that the one side doesn't care about the child. But ultimately it is my belief that history and time will point out that abortion on demand has been the ultimate war on women and America is better than this.

With that, it concludes today's hearing. I want to thank our witnesses for attending. Without objection, all Members will have 5 legislative days to submit additional written questions for the witnesses and additional materials for the record.

I thank the witnesses and I thank the Members and the audience, and this hearing is adjourned.

[Whereupon, at 11:45 a.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Statement of the Honorable John Conyers, Jr.
for the Hearing on H.R. 7, the "No Taxpayer Funding for Abortion Act"
Before the Subcommittee on the Constitution and Civil Justice

Thursday, January 9, 2014 at 10:00 a.m.
2141 Rayburn House Office Building

Today's hearing on H.R. 7 is yet another attempt to push a divisive social agenda instead of focusing on what Americans care most about: creating jobs and improving our Nation's economy.

Rather than addressing these critical issues, my colleagues on the other side of the aisle have chosen to use the first hearing of 2014 to attack – yet again – women's health and their constitutionally-protected rights.

To begin with, we must acknowledge that this hearing sadly reflects the Majority's relentless on-going anti-woman, anti-family, and anti-child agenda, which dates back to the last Congress.

For example, the GOP-led government shutdown last October robbed *more than 9 million* women and children of critical supplemental food assistance and health care referrals under the Women, Infants, and Children Program, known as WIC.

The shutdown also left 19,000 children without early education and necessary social services provided by Headstart.

Let's be clear. The so-called "No Taxpayer Funding for Abortion Act," is not really about prohibiting federal funding abortion. Federal law already prevents that.

The real goal of this bill is to make abortion and coverage for abortion services paid for by *private* individuals with their *own* money unavailable.

It does this by adding restrictions and imposing an unprecedented penalty – by use of the federal tax code – on **privately-funded** health care choices made by women in consultation with their family and their faith.

Let me also point out that the version of this legislation that we considered in the last Congress would have narrowed the already inadequate exceptions for rape, by further limiting funding to cases of "forcible rape."

According to Mr. Doerflinger, who is here again with us today, this "forcible rape" limitation was intended to "prevent the opening of a very broad loophole for federally funded abortions for any teenager."

What a shocking admission.

Fortunately, the Majority responded to the justifiable fury over this outrageous limitation by removing the term "forcible" from the bill's text.

Unfortunately, they made clear in the Committee Report that accompanied this bill that they still intended to prevent the federal government from subsidizing "abortion in case of statutory rape," an exception that directly conflicts with the Hyde Amendment, which makes funding available in *all* cases of rape.

H.R.7 also endangers women's health by denying coverage *even where an abortion is necessary to protect the health of a woman*, in complete disregard of the Supreme Court's dictates in *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey.*

Further, the bill targets women in the District of Columbia by usurping the ability of the District's local elected officials to use local revenue to provide access for abortion care.

No Member would tolerate that level of intervention into local decisions to spend local money. Yet here we are again treating Americans who live in the District like second-class citizens.

Finally, H.R. 7 makes an unprecedented use of the Internal Revenue Code to penalize private health care decisions by denying tax deductions, credits, and benefits for money spent to cover out-of-pocket medical expenses related to abortion services or to purchase health insurance that includes such services.

Let's call this legislation exactly what it is: a tax increase on individuals, families or small employers who make a particular health care choice that some of my colleagues do not like.

The overall impact of this bill is clear: It will discourage most insurers from including coverage for abortion services in health insurance plans, which will effectively eliminate coverage that families across America now have and now pay for with their *own* money.

In sum, this bill is a travesty.

Material submitted by the Honorable Jerrold Nadler, a Representative in Congress from the State of New York, and Ranking Member, Subcommittee on the Constitution and Civil Justice

Statement by Rep. Jerrold Nadler
Ranking Democratic Member
Subcommittee on the Constitution

Hearing on: H.R. 7,
"No Taxpayer Funding for Abortion Act"
January 9, 2014

Thank you, Mr. Chairman.

Today's hearing concerns what may be the most difficult and divisive issue we will have the opportunity to consider – a woman's right to make decisions about her own body. The right of a woman to decide whether to become pregnant and whether to continue or terminate her pregnancy is protected by the Constitution. Whether or not you think that is a good idea, or a fair reading of the Constitution, it remains the law of the land.

The Supreme Court has also determined that neither congress nor a state may place an "undue burden" on that right.

Now comes H.R. 7, the "No Taxpayer Funding for Abortion Act," which is misleading and misnamed, because the bill seeks to burden *all* women's health care choices in a variety of ways that have nothing to do with Federal funds. Contrary to the assertions of its supporters, H.R. 7 is not the mere codification of existing law.

This bill seeks to extend current funding restrictions in the Hyde Amendment that are limited in time and scope and apply them to all Federal laws, without any effort to determine how such a sweeping and permanent expansion would impact American women and their families. If this were all, that would

still be reason enough to oppose it, but H.R. 7 actually goes much further. This bill – for the first time ever – denies tax deductions and credits for women who use their own money to pay for abortion or to purchase insurance that covers abortion and – in so doing – increases taxes for women and families with respect to one of the most personal and private decisions that they may face.

In particular, H.R. 7 denies the itemized tax deduction that otherwise is available for medical expense if the expense is abortion, and treats as taxable income any distribution from a flexible spending account or health savings account that is used to pay for abortion expenses. H.R. 7 denies small employers the ability to use tax credits to provide health coverage if that coverage includes abortion. The bill also denies income-eligible

women the use of premium tax credits available under the Affordable Care Act if selected insurance coverage includes abortion.

In first opposing, and then voting to repeal, the Affordable Care Act – not once, not twice, but I think we're up to 47 times now – my Republican colleagues have complained that government should not meddle in the private insurance market, or in private health care choices. But this legislation obviously is designed to do just that. It seems that many Republicans believe in freedom provided no one uses that freedom in a way that they do not approve. That is a strange understanding of freedom.

Even more stunning, this bill increases taxes on families, businesses, and the self-employed if they spend their own money – let me repeat that: their own money – on abortion coverage or services. As we know, the power to tax is the power to destroy, and, here, the taxing power is being used to destroy the right of every American woman to make private health care decisions free from government interference. And this tax increase is being championed by Republicans, almost all of whom have taken a pledge not to raise taxes on individuals or businesses.

I am equally surprised to find out that my Republican colleagues think that a tax exemption or credit is a form of government funding. Should we now consider every tax exemption or credit as a form of government funding for the

recipient? I'm sure that there will be many businesses, charities, and religious denominations that will be alarmed to discover this.

I also join many other Americans in being absolutely horrified that the Majority of this Committee seem not to know what rape is.

When this bill was introduced in the last Congress, its sponsors sought to limit the Hyde Amendment rape exception to instances of "forcible" rape. Many in Congress and across America were outraged. According to the bill's champions, date rape drugs and sex with minors were not really rape.

In the face of public outcry, the Majority removed the term "forcible" from the bill before this Committee marked it up in the last Congress.

But let no one misunderstand or be fooled by that change. My colleagues still seek to narrow the rape exception, as they made clear in the Committee report accompanying H.R. 3 in the last Congress (House Report No. 112-38). As they explained:

"Reverting to the original Hyde Amendment language should not change longstanding policy. H.R. 3, with the Hyde Amendment language, will still appropriately *not* allow the Federal Government to subsidize abortions in cases of statutory rape. The Hyde Amendment has not been construed to permit Federal Funding of abortion based solely on the youth of the

mother, nor has the Federal funding of abortions in such cases ever been the practice."

The Majority's assertion – as explained in a memo from the National Women's Law Center – is false. In fact, a 1978 regulation clarified that funding is required for all cases of rape, whether statutory or forcible. Nothing in the language of the Hyde Amendment qualifies the term "rape," and Congress rejected a proposal to limit the Amendment to cases of "forced" rape. As explained in the 1978 regulation, and as remains true to this day, Congress's "failure to use the word 'forced' in [the Hyde Amendment] when referring to rape is conclusive evidence that congress intended funding to be available for victims of statutory, as well as forced, rape . . . " I ask

unanimous consent that the National Women's Law Center memo be entered into the record.

In their Committee report, my colleagues displayed their true intent with regard to the exception for rape, which is to remove federal assistance for children and teenagers who are the victims of predators.

They have not been as transparent about the overall intent behind this bill. But it is nonetheless clear: it is to end insurance coverage for medically indicated abortions for all women, whether or not they obtain their insurance on an exchange, and even if they use their own money to purchase the insurance.

My colleagues in the majority believe that if you like your insurance coverage, you should get to keep it, unless it is for choices that they don't like. Then, they have no qualms about taking your coverage away.

That is the intended and likely result of this bill. Currently, the vast majority of insurance products cover abortion services. But, as Professor Sara Rosenbaum of George Washington University's School of Public Health testified in the last Congress, insurance companies will respond to the tax penalties this bill imposes by dropping coverage for abortions from all of their plans. This will have a significant impact on *all* women, not just lower income women who have long felt the brunt of federal restrictions on their health care choices.

My colleagues blithely assert that coverage will be available, if in no other way, through supplemental insurance policies. But – as Professor Wood, the witness invited by the Minority can explain – there is no evidence that such product lines are being developed.

H.R. 7 is not codification of existing law, nor is it just another attempt to enact the approach taken in the Stupak/Pitts Amendment to the House-passed Affordable Care Act. H.R. 7 is a radical departure from current tax treatment of medical expenses and insurance coverage; and it is neither justifiable nor necessary to prevent Federal funding of abortion.

I yield back the balance of my time and look forward to hearing from our witnesses today.

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January 16, 2014

Chairman Trent Franks
Subcommittee on the Constitution and Civil Justice
Committee on the Judiciary
US House of Representatives

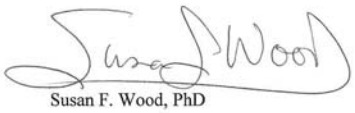
At last week's hearing on H.R.7, I was asked by Representative Forbes if there were any medical procedures that a pregnant woman seeking an abortion might undergo to which I object.

My answer to that question is: The *only* appropriate procedure for a pregnant woman, including one seeking abortion services, is one that is appropriate for her medically, according to accepted standards of care; that is provided by a health-care professional who is properly trained, credentialed, and licensed, using his or her best medical judgment; that is administered in a hygienic, properly regulated, and safe environment; and for which a patient's appropriate informed consent has been obtained. I believe that if a medical procedure meets these standards, it is not appropriate for any third party, including politicians, to interfere.

Thank you for inviting me to testify at the hearing and for permitting me to submit this answer for the record.

Attached for the record is a final copy of my written testimony, as well as a copy of the Memo by Rosenbaum et al. on the impact of the Stupak/Pitts Amendment to the Affordable Care Act, as was discussed at the hearing.

Sincerely



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DEPARTMENT OF HEALTH POLICY

An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions

Sara Rosenbaum
Lara Cartwright-Smith
Ross Margulies
Susan Wood
D. Richard Mauery

November 16, 2009

Introduction and Results in Brief

This analysis examines the implications for coverage of medically indicated abortions[1] under the Stupak/Pitts Amendment (Stupak/Pitts) to H.R. 3962, the Affordable Health Care for America Act.[2] In this analysis we focus on the Amendment's implications for the health benefit services industry as a whole. We also consider the Amendment's implications for the growth of a market for public or private supplemental coverage of medically indicated abortions. Finally, we examine the issues that may arise as insurers attempt to implement coverage determinations in which abortion may be a consequence of a condition, rather than the primary basis of treatment.

Industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women: In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, we conclude that the treatment exclusions required under the Stupak/Pitts Amendment will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange. As a result, Stupak/Pitts can be expected to move the industry away from current norms of coverage for medically indicated abortions. In combination with the Hyde Amendment, Stupak/Pitts will impose a coverage exclusion for medically indicated abortions on such a widespread basis that the health benefit services industry can be expected to recalibrate product design downward across the board in order to accommodate the exclusion in selected markets.

Supplemental insurance coverage for medically indicated abortions: In our view, the terms and impact of the Amendment will work to defeat the development of a supplemental coverage market for medically indicated abortions. In any supplemental coverage arrangement, it is essential that the supplemental coverage be administered in conjunction with basic coverage. This intertwined administration approach is barred under Stupak/Pitts because of the prohibition against financial comingling. This bar is in addition to the challenges inherent in administering any supplemental policy. These challenges would be magnified in the case of medically indicated abortions because, given the relatively low number of medically indicated abortions, the coverage supplement would apply to only

[1] In this analysis, the term "medically indicated abortion" means any type of abortion for which there is a medical indication of need, as distinguished from abortions that have no medical evidence to justify insurance coverage.
[2] Affordable Health Care for America Act, H.R. 3962, 111th Cong. (1st Sess. 2009). Available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962eh.txt.pdf.

a handful of procedures for a handful of conditions. Furthermore, the House legislation contains no direct economic incentive to create such a market. Indeed, it is not clear how such a market even would be regulated or whether it would be subject to the requirements that apply to all products offered inside the exchange. Finally, because supplemental coverage must of necessity commingle funds with basic coverage, the impact of Stupak/Pitts on states' ability to offer supplemental Medicaid coverage to women insured through a subsidized exchange plan is in doubt.

Spillover effects as a result of administration of Stupak/Pitts. The administration of any coverage exclusion raises a risk that, in applying the exclusion, a plan administrator will deny coverage not only for the excluded treatment but also for related treatments that are intertwined with the exclusion. The risk of such improper denials in high risk and costly cases is great in the case of the Stupak/Pitts Amendment, which, like the Hyde Amendment, distinguishes between life-threatening physical conditions and conditions in which health is threatened. Unlike Medicaid agencies, however, the private health benefit services industry has no experience with this distinction. The danger is around coverage denials in cases in which an abortion is the result of a serious health condition rather than the direct presenting treatment.

The remainder of this analysis examines these issues in greater detail.

Overview of Current Federal Law

1. *The Hyde Amendment and Medicaid*

The Hyde Amendment has been part of each HHS-related appropriation since FY 1977. As set forth in the most recent annual Labor/HHS federal appropriations legislation,[3] the Hyde Amendment provides in pertinent part as follows:

> Sec. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion.
>
> (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.
>
> (c) The term 'health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.
>
> Sec. 508. (a) The limitation established in the preceding section shall not apply to an abortion-
>
> (1) if the pregnancy is the result of an act of rape or incest; or
>
> (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

[3] Omnibus Appropriations Act, Pub. L. No. 111-8, 123 Stat. 524, 802-803 (Mar. 11, 2009).

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a state or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds) * * *

Under this Amendment, states may neither directly expend federal funds for abortion other than the procedures authorized by the Amendment nor use federal and matching state funds to purchase products that cover a broader range of abortions. At the same time, the Amendment preserves states' authority to either pay for, or purchase coverage of, additional abortion services using state and local funds that exceed federal Medicaid contribution requirements. Twenty-three states currently pay for some abortion services that extend beyond the limited range of coverage permitted under the Hyde Amendment and seventeen of those pay for all or most medically necessary abortions.[4]

2. The Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act (ERISA) governs private employer-sponsored coverage in the U.S. Because most workers are employed by private firms, ERISA has a broad reach, affecting health plans that account for 81 percent of all persons covered by any employer-sponsored arrangement. The remaining population of workers and their dependents are enrolled in an ERISA-exempt plan (typically a plan offered by government employers and subject to separate legal requirements).[5]

ERISA contains few provisions regulating the content of employer-sponsored health benefit plans. Instead, the law relies on the health benefit services companies that sell products to employers, as well as employers themselves, to negotiate the terms of coverage. Despite the considerable investment of taxpayer financing that supports the employer-sponsored system (currently estimated at $246 billion),[6] ERISA contains no mandatory exclusion of certain types of medically indicated treatments for abortion, instead leaving the matter to the discretion of purchasers and sellers. The best available research indicates that 87 percent of employer-based insurance plans cover medically appropriate abortions and that 46 percent of workers have coverage that includes some level of abortion services.[7]

The fact that an employer plan is subject to ERISA does not render state insurance law irrelevant. ERISA health benefit plans that cover participants and members by buying a health insurance product

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[4] Guttmacher Institute, State Funding of Abortion Under Medicaid, *State Policies in Brief*, 2009. Available at http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

[5] Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA. (GAO/HEHS-95-167, July 25, 1995).

[6] Joint Committee on Taxation. *Tax Expenditures for Health Care* (JCX-66-08), July 30, 2008. This document is available at www.jct.gov.

[7] Two major studies have been conducted on this issue. A federally supported study conducted by the Guttmacher Institute and assessing levels of insurance coverage for a wide range of reproductive health services found that in 2002, 87% of typical employer-based insurance plans covered medically necessary or appropriate abortions. In a 2003 survey, the Kaiser Family Foundation found that 46% of insured workers had some level of abortion coverage. The number may be even higher considering that the survey also yielded a high (26 percent) "don't know" response rate. Guttmacher Institute, Memo on Insurance Coverage of Abortion, updated Sept. 18, 2009.
http://www.guttmacher.org/media/inthenews/2009/07/22/index.html.

are subject to state law with respect to the products that are purchased. Thus, state insurance content mandates or regulatory exclusions could affect certain ERISA plans. (In contrast, ERISA health benefit plans that self-insure are exempt from state insurance law.)

States exercise their powers under the McCarran-Ferguson Act[8] to regulate insurance, but only rarely regulate the terms of abortion coverage in the individual or group markets. Currently, five states[9] appear to regulate coverage of medically indicated abortions by banning coverage of most procedures except where the life of the mother is in danger. These state laws effectively impose a mandatory, regulatory coverage exclusion directly affecting benefit design of insurance products sold in their states. These states also allow for the sale of separate abortion riders, but the evidence available shows that markets for abortion-specific insurance products have not developed in these states.[10]

The Federal Employee Health Benefits Program

The Federal Employee Health Benefits Program (FEHBP) reaches some 8 million beneficiaries, including federal employees and their spouses and dependents.

Unlike the ERISA market, the laws governing health benefit coverage for federal employees directly regulate abortion content. The annual federal appropriations statute governing the program provides in pertinent part as follows:

> Sec. 613. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefits program which provides any benefits or coverage for abortions.
>
> Sec. 614. The provision of section 613 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.[11]

Like the laws in the five states that have elected to regulate plan content, this statute reaches plan content by imposing a coverage exclusion on plans sold to federal employees, barring coverage for most medically indicated abortions. Furthermore, the legislation bars payments to any health plan that administers coverage reaching the prohibited types of treatments. This bar conceivably could cost a plan its federal contract even if its plan administration activities were limited to the coordination of benefits between its own product and a supplemental product offering coverage of excluded

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[8] 15 U.S.C. §§ 1011-1015.

[9] ID, KY, MO, ND, OK. OK limits coverage to life endangerment, rape or incest circumstances; and the other four states limit coverage to cases of life endangerment. Guttmacher Institute. Restricting insurance coverage of abortion. *State Policies in Brief*, 2009.

[10] Insurance departments in Idaho, Kentucky and Missouri say they do not track the existence of such riders (although presumably the content of such riders would have to be registered with a state's insurance department). It is very unclear if any riders are offered. North Dakota and Oklahoma officials report that insurers do not currently offer such riders. Oklahoma reports that one insurer has filed for a rider to offer abortion coverage to small groups, but apparently has not yet offered that coverage. Idaho reports that one of the state's major insurers will offer abortion coverage to small groups if they pay an additional premium charge. *How Would the House Abortion Limits Work?* MSNBC. http://www.msnbc.msn.com/id/33859329/ns/health-health_care

[11] The Omnibus Appropriations Act, 2009 (Pub. L. 111-8).

treatments. For this reason, it would appear that companies selling products to federal employees would not be permitted to offer supplemental abortion coverage without risking the loss of their plan administration financing unless they could demonstrate that the sale and administration of such a rider was completely segregated from general plan administration. This would be virtually impossible, since coverage determinations related to the supplement would of necessity have to be coordinated with the basic plan, causing administrative spillover into the base plan. While a federal employee in a state in which supplemental coverage is offered might buy such a supplement, not only is there no evidence that such a market exists, but the base plan would be barred from coordinating benefits with the supplemental insurer, thereby leaving the employee exposed to the risk of coverage denial from all sources of coverage.

There is evidence that in the absence of exclusion, the coverage norm would be to include a range of medically indicated abortion procedures. In 1994, the last year when products were not subject to such coverage exclusion, half of all products sold in the FEHBP offered at least some abortion coverage beyond the current limited coverage.[12]

Interactions between regulatory law and the health benefit services industry

In the absence of federal or state regulatory laws governing the design and administration of health benefits, the health benefit services industry has the discretion to design and administer products in accordance with market preferences. As noted, it appears to be customary for the industry to cover medically indicated abortion procedures, with 87 percent of health benefit plans offered reporting coverage of abortion services.[13]

Once regulatory law is introduced however, industry norms can begin to shift if the reach of the law is broad enough to affect a significant portion of the market. The health benefit services industry, like any large producer of goods and services functioning in a national economy, depends on standardization and norms. If certain types of products are excluded in certain large markets, over time the market as a whole for the product can be expected to shift, as manufacturers move to accommodate their product to reflect the regulated design. This is particularly true where the regulation deals with details of the product, that is, where the regulation attempts to redesign certain product details rather than some substantial aspect of the product that can be readily modified for certain customers. The analogy here would be regulations that address the inner workings of a car engine (crucial and detailed) rather than the color of a car, which can be modified with relative ease to satisfy the desire of certain customers (e.g., a red car with black trim).

The effect of regulatory law where the content of insurance coverage is concerned can be seen in the changed market for insured contraception. Prior to the enactment of state contraception coverage mandates, most health plans did not provide the benefit. As state laws regulating the inclusion of contraceptives have become more prevalent, the broader health benefit services market has been

[12] Center for Reproductive Rights. Federal Employees Deserve Comprehensive Reproductive Health Care (NY, NY, July 2009)
[13] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates, 2002*. Perspectives on Sexual and Reproductive Health, 36(2):72–79 (2004).

affected.[14] National health benefit services companies report today that they routinely include contraceptive coverage in their plans in all markets, not only those directly affected by state law.[15]

This potential for regulation to spill over into unregulated markets can be expected to work in reverse, particularly where the regulation prohibits specific procedures and conditions and creates additional disclosure, network design, coverage determination, and provider payment complexity for plan administrators. The same national and regional companies that sell products in the private employee, federal-employee or the state-regulated markets can be expected to sell products in the exchange markets; indeed, a goal of health reform is to create a large new market of high quality insurance products for the 30 million people who will derive coverage through the exchange. Until now, the very large private employer market has been a dominant force in product design. But as the exchange market grows, its design requirements – particularly when combined with those from the large emerging Medicaid managed care market and the federal employee benefits market – can be expected to gain real dominance.

The critical task for companies faced with multiple markets, will be to design products that can compete in all markets. For example, Blue Cross of the National Capital Area might sell a PPO product in multiple forms: as a Medicaid managed care product; as a state-licensed insurance product in the individual and small group markets; as a product for federal employees; as an administered product in the self-insuring employer market; and finally as an insured product in the exchange. The company will want the plan "engine" to operate as much the same as possible across all markets, even if the "color and trim" aspects of its products (e.g., a benefit package supplement for vision and dental or its prescription drug plan) may vary for certain markets.

To be sure, sellers of health benefit services products do customize those products in certain ways, varying cost-sharing for example or adding entire benefit classes (such as a dental coverage supplement). But in the case of abortion services, the issue is not adding an entire benefit class that can be clearly described and efficiently administered. Instead, the challenge is to customize in certain critical but small-bore ways the range of procedures that a plan administrator will cover and the specific types of patients for whom additional procedures will be made available. Abortion regulations that allow coverage of most medically indicated procedures for most health conditions but prohibit a few procedures for a handful of conditions essentially compel changes in the inner workings of plan administration. Thus, as more and more markets demand these changes, the plan's inner workings must change as well.

In effect, in order to preserve broader coverage of medically indicated abortions, the health benefit services industry will confront the challenge of adding coverage procedure by procedure for specific women and based on the specific details of their underlying health conditions. Accomplishing this task -- or offering an entirely separate plan that operates according to a separate set of rules -- will pose a major burden on the industry, one that it might undertake were it to receive direct financial incentives for doing so, or were it to conclude that the market is large enough. But where the market is for a handful of medical procedures for a small number of conditions – as crucial as they might be – the

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[14] Guttmacher Institute, Insurance coverage contraceptives. *State Policies In Brief*, http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf, accessed November 13, 2009.
[15] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates, 2002*. Perspectives on Sexual and Reproductive Health, 36(2):72–79 (2004).

burdens associated with administering a parallel plan or a supplemental product will quickly work to outweigh the economic benefit of offering more product choice.

In sum, while the additional coverage of medically indicated abortions may be minimal from an actuarial viewpoint, as studies of contraceptive coverage have suggested,[16] the administrative burdens can be considerable. Enrollment materials and summary plan benefit materials would need to be altered to reflect broader coverage for members who buy additional coverage either as a separate plan or via a coverage supplement. Individual coverage determinations will differ for women depending on the procedures to be used, the severity of their health conditions, and the medical evidence in the case. Coverage determinations and grievance and appeals procedures will have to be separately administered to respond to different coverage rules. Medical provider networks may have to be augmented in order to make the fuller range of coverage accessible to members, with separate negotiated payment rules. Most importantly, extensive interaction in order to coordinate benefits between the basic plan and the supplemental plan (or the separately purchased coverage supplement) is necessary to assure that costs are apportioned properly and that coverage risks are distributed according to the terms of the plan.

For example, consider a case in which an abortion is medically indicated as a result of a woman's health. In this case, coverage might be available through a basic plan if the condition were determined to be life-threatening, but only through the supplemental plan if the condition that led to the abortion were determined to only threaten her health. Making such a determination might be difficult, particularly where the health threat is severe and long-lasting. Significant interaction between the administrators of the basic and supplemental plans would be essential to resolve the evidence; where the administrator is the same person, the task inevitably would require construing the plan terms across all products.

One can begin to appreciate why the market for supplemental coverage is limited. Where companies are precluded from participating in markets if they offer certain abortion services, offering alternative plans or a supplement leaves them exposed to the risk that in administering the supplement in relation to the base plan they will be considered to be administering a prohibited product. The only way to avoid this outcome might be to assure that the cost of the supplement is high enough to absorb all administrative costs over both the base plan and the supplement, as well as the actuarial risk of need. Making this type of adjustment would of course drive up the price of the product.

The legal risks inherent in offering a supplement in a market that legally prohibits the commingling of plan administration duties can be expected to drive the industry away from the sale of a plan supplement. These problems are compounded by the fact that the market can be expected to be extremely small where the product is not for a broad swath of benefits such as vision and dental care but instead for a handful of procedures for a handful of serious conditions.

Thus, it is not surprising that the supplemental coverage market for medically indicated abortion procedures that are excluded from a basic plan has not grown, either for federal employees or in states that prohibit basic abortion coverage. There are just too many difficulties – legal and technical – to justify the cost, and the market is infinitesimal when one considers the handful of women who might need this critical protection. While the numbers of women in need of this additional coverage are of

[16] "Contraceptive Coverage Must Be Included in the Federal Employees Health Benefits Program," National Women's Law Center. http://www.nwlc.org/pdf/federalconcov.pdf.

course small, the financial risks that the absence of the protection creates for families can of course be considerable, since medically indicated abortions, when undertaken in response to serious health conditions, can run into the thousands of dollars.

The Stupak/Pitts Amendment

On November 7, 2009, during floor debate on the Affordable Health Care for America Act (H.R. 3962), the House adopted the Amendment offered by Representatives Stupak and Pitts to broaden the bill's prohibition on federal funding for abortion.[17] The Amendment provides in pertinent part as follows:

> (a) IN GENERAL -- No funds authorized or appropriated by this Act . . . may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.
>
> (b) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN – Nothing in this section shall be construed as prohibiting any nonfederal entity (including an individual or a state or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as –
>
> (1) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act, and
>
> (2) such coverage or plan is not purchased using (A) individual premium payments required for a Exchange participating health benefits plan towards which an affordability credit is applied; or (B) other nonfederal funds required to receive a federal payment, including a state's or locality's contribution of Medicaid matching funds.
>
> (c) OPTION TO OFFER SEPARATE SUPPLEMENTAL COVERAGE OR PLAN – Notwithstanding [the foregoing] nothing in this section shall restrict any nonfederal QHBP offering entity from offering separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as –
>
> (1) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated under this Act
>
> (2) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and
>
> (3) any nonfederal QHBP offering entity that offers an Exchange-participating health benefits plan that includes coverage for abortions for which funding is prohibited under this section also offers an Exchange-participating health benefits plan that is identical in every respect except that it does not cover abortions for which funding is prohibited under this section.

[17] 155 Cong. Rec. H12962 (Nov. 7, 2009).

The Amendment, as passed, thus appears to represent an amalgam of the Hyde Amendment and the FEHBP coverage exclusion provision in its construction. Summarized as follows, the Amendment would:

- Prohibit the use of funds under the Act either to directly pay for abortion or to buy an exchange product that covers abortions other than the narrow range of permissible abortions.
- Prohibit the coverage of all but the allowable abortions under the public plan.
- Permit states and localities to use their own funds either to pay directly for abortions or to buy a plan covering abortion, as long as the purchase is with funds other than mandatory state expenditures under the Act.
- Permit companies to sell supplemental coverage or plans that include broader abortion coverage, but only to the extent that "administrative costs and all services offered through such supplemental coverage or plan" are paid for using only "premiums collected for such coverage or plan."
- Prohibit companies from offering supplemental coverage or plans that cover abortions unless they also offer an exchange plan that is identical in every respect except that no prohibited abortion coverage is included.

The Potential Impact of the Stupak/Pitts Amendment

The Stupak/Pitts Amendment can be expected to influence the industry as a whole by considerably broadening the market for products that exclude all but a limited number of abortion procedures. The Congressional Budget Office projects that within six years of the exchange being implemented, 30 million people will get their health insurance through the exchange, including three million who will not receive subsidies and nine million who will receive exchange-based coverage through their employer.[18] In effect, the size of the new market is large enough so that Stupak/Pitts can be expected to alter the "default" customs and practices that guide the health benefits industry as a whole, leading it to drop coverage in all markets in order to meet the lowest common denominator in both the exchange and expanded Medicaid markets.

Furthermore, for the reasons outlined above, because the Stupak Amendment bars the subsidization of plan administration activities in connection with prohibited procedures, it can be expected to chill the development of abortion coverage supplements as well as entirely separate plans to non-subsidized women. The refusal of plans to engage in plan administration in connection with broader coverage arrangements may also begin to affect access to abortion coverage in states that voluntarily offer such coverage under Medicaid if plan administrators seek to avoid coordination of benefits activities across basic and supplemental coverage.

[18] Congressional Budget Office, Letter to Rep. Dingell, Nov. 6, 2009. Available at http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_Amendment_update.pdf.

Finally, the Amendment can be expected to have spillover effects on plan administration activities in connection with abortions related to women with serious health conditions that result in abortion, even where abortion is not the primary treatment sought, which may result in the denial of coverage for a broad range of medical treatments. This result flows from the difficulties associated with administering exclusions tied to a limited range of medically indicated procedures.

1. Impact on currently uninsured women and women who are employees (or spouses or dependents of employees) of small businesses

Of the 12.02 million women ages 18-45 who are classified as uninsured under the 2009 Current Population Survey, more than 10.5 million have family incomes below 400% of the federal poverty level,[19] the income cutoff for subsidies in the Senate Finance Committee measure.[20] These women will qualify either for coverage through Medicaid or for a subsidized exchange product. They will be barred from enrolling in plans with abortion coverage exceeding Hyde Amendment or Stupak/Pitts Amendment restrictions. States might subsidize a broader range of abortion procedures for these women, but the Stupak/Pitts provisions barring the commingling of funds in relation to plan administration may lead plans to resist coordination of benefits efforts with state programs. A plan that cooperates with a state Medicaid agency may be determined to put its own exchange or federal employee benefit plan participation at risk.

The small number of more affluent women (those earning too much to qualify for a subsidy) who gain access to individually-purchased exchange products might be able to afford to purchase supplemental coverage for additional medically indicated abortion procedures (if such a supplement exists) or a supplemental plan. But the Stupak/Pitts Amendment effectively requires that this additional coverage be administered separately from other plans. As a result, the cost of the supplement or the separate plan could be expected to be far higher than simply the cost of the additional procedures, as noted above. In other words, compared to other conditions, the cost of supplemental coverage for certain medically indicated abortions would be disproportionately high because of the additional administrative expenses resulting from the Amendment. This added cost can be expected to drive down the market, leaving women in need of these procedures with serious financial exposure.

Medically indicated abortions carried out early in pregnancy may be relatively inexpensive. But the cost of abortions performed later in pregnancy and as part of other treatment for serious health conditions could be considerable. Indeed, medically indicated abortions carried out later in pregnancy and flowing from underlying health conditions or severe fetal abnormalities can carry a price tag in the thousands of dollars.[21] With the risk of cost for these conditions effectively excluded from the larger risk pool, the cost of a supplement or a plan that carries additional coverage could be considerable.

Women covered through small employers that elect to purchase coverage through the exchange would confront the same barriers as individual women who do not receive subsidies. Approximately 36

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[19] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.
[20] America's Healthy Future Act of 2009, S. 1796, 111th Cong. (1st Sess. 2009), Sec. 1206.
[21] Stanley Henshaw and Lawrence Finer, *The Accessibility of Abortion Services in the United States, 2001*, Perspectives on Sexual and Reproductive Health, 35(1):16-24 (2003) (nonhospital surgical abortion charges ranged up to $3000 at 16 weeks and $2000 at 20 weeks); Agency for Healthcare Research and Quality, National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample, 2007 (mean charges for threatened abortion, abortion without D&C, and abortion with D&C, aspiration curettage or hysterotomy were $9,964 to $13,802).

percent of employees work for small employers (those with 99 or fewer employees).[22] If it is assumed that the figure is comparable for women and men, then millions of women who today derive coverage through small employers might be affected, depending on the extent to which small employers switch to exchange purchasing.[23]

To the extent that small employers migrate into the exchange system (as envisioned), the impact on employer-sponsored abortion coverage could be considerable as smaller employers that now regularly include abortion coverage in their plans move into a market in which similar plans may no longer be available unless specially marketed either as more comprehensive plans or as more limited plans linked to an abortion supplement. Simply put, the market for these women is highly speculative. Because the bills contemplate opening the exchange to employer plans of increasing size over the years,[24] the impact of the Stupak/Pitts Amendment on women with employer-sponsored coverage could be dramatic, especially since there is no indication that companies would develop comprehensive or supplemental products that cover a wider range of medically indicated abortions.

To be sure, a migration over time of thousands of smaller employers might encourage health benefit services companies to create supplemental abortion coverage products or offer plans that provide for more generous abortion coverage. But two facts militate against this. The first is the virtual non-existence of supplemental coverage products to date in states that bar the sale of products that offer abortion coverage. The second is that in contrast to a program such as Medicare Part D, which creates supplemental coverage for an entire class of benefits (prescription outpatient drugs), no federal policy will offer a financial stimulus for the creation of such a market. Indeed, federal policy is designed to push the price of supplemental coverage higher by prohibiting the integration of administration costs into a single administrative scheme.

2. Impact on women covered by large employers outside of the exchange

Ostensibly the Stupak/Pitts Amendment does not have a direct effect on large employers operating outside the exchange. At the same time, the Senate Finance Committee measure allows subsidies for individuals for whom employer coverage is not affordable or whose employer plans have low actuarial value. The interaction between public support to persons covered under ERISA plans and the Amendment is unclear. Even were a bright line to be maintained, with such individuals removed from their plans and enrolled in exchange plans, the interaction between the markets could further drive the industry to shift away from current abortion coverage norms and toward product designs that meet exchange and Hyde Amendment requirements.

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[22] U.S.Census Bureau, Statistics about Business Size (including Small Business), Employment Size of Employer and Nonemployer Firms, 2004.
[23] Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, 2009. (There are approximately 67 million women over 16 currently in the workforce, of which 36 percent may be assumed to work in small businesses.)
[24] The House bill would permit employers with more than 50 employees to participate in beginning in 2015 and the Senate Finance Committee's bill would permit states to open their exchanges to large firms with over 100 employees starting in 2017. Affordable Health Care for America Act, H.R. 3962, 111th Cong. (1st Sess. 2009), Sec. 202(c)(3); America's Healthy Future Act of 2009, S. 1796, 111th Cong. (1st Sess. 2009), Sec. 1101 (new Sec. 2230(a); 2235(d)).

3. Impact on the health benefit services industry

Withdrawing coverage of medically indicated abortions from all markets

For the reasons noted above, health benefit services companies operating in either the Medicaid or exchange markets could be expected to resist offering coverage supplements or broader plans, since the legal and technical complexities of doing so far outweigh the potential market for the products. Not only would companies have to absorb all costs of administration into the supplemental or separate plan fee, but companies would confront having to expand provider networks to assure access to the full range of medically indicated abortions in the case of women who purchase expanded coverage. Health care providers can be expected to resist participating in supplemental networks if only because they will resist making their services available to some but not all of their insured patients, without any clear idea of which patients have which level of coverage. Furthermore, companies that offer supplemental coverage or separate plans may find extensive unwillingness to participate among providers that refuse to furnish abortions; while the legislation prohibits plan discrimination against providers that refuse to furnish abortions, it does not protect plans from providers who refuse to join a plan that offers broader coverage for medically indicated abortions, even if the provider does not have to furnish the treatment.

Furthermore, as the proportion of women of childbearing age covered by an abortion-related treatment exclusion grows, companies offering coverage products in the employer-sponsored market ultimately may elect to simply remove the procedures from their products so that they can be sold in all markets. Under these circumstances, what is the norm today in the employer-sponsored market – broad coverage of medically indicated abortions – is likely to narrow considerably as the industry seeks to restructure its product design to meet the most restrictive demands. If this consequence flows, then the industry, confronting the challenges of distinguishing between enrollees for a handful of covered procedures and specific conditions, can be expected simply to eliminate certain procedures and conditions from coverage altogether, leaving women and families exposed.[25]

The spillover problem of coverage denials where the need for an abortion is secondary to the treatment of a medical condition

An additional consideration is the potential for spillover effects from the administration of an exclusion that imposes a life-threatening coverage standard. If the entire industry moves to this life-threatening standard, it is likely that all women will risk coverage denials, regardless of the market in which their coverage is obtained.

Stupak/Pitts and Hyde, for that matter, presume that abortion is the immediate subject of the claim for coverage. In these cases, plan administrators must make complex decisions about whether treatment is for a life threatening condition or one that threatens health. But difficulties mount where the abortion procedure is part of broader treatment for a serious health condition, essentially an unfortunate downstream consequence of upstream treatment for a significant health problem, leading to the unwanted loss of a pregnancy. In these circumstances, how are plan administrators to distinguish between the abortion procedure and the rest of the treatment? Will the entire cost of a course of treatment (e.g., surgery to repair a damaged pelvis following an automobile accident) be denied if

[25] Interview with Robert Laszewski. Health Bill Abortion Clause May Derail Insurance, Julie Rovner, *National Public Radio*. November 14, 2009.

abortion is part of the procedure? Health plan administrators, confronted with the prospect of a legal violation for paying for the excluded abortions, may elect to deny the treatment altogether, claiming that it is all related to the excluded treatment. As the denial is appealed, the financial consequences for patients potentially will be enormous.

This tendency to exclude entire classes of treatment where coverage of a particular treatment for a particular underlying condition is excluded can be seen in the case of HIV/AIDS, where the exclusion typically runs not only to HIV/AIDS itself, but also to conditions and health problems that are considered "AIDS-related."[26] High risk pregnancies themselves could be identified as potentially abortion-related. Conditions such as diabetes (observed in 1% of pregnancies[27]) which are poorly controlled can lead to serious health consequences for both the woman and the fetus, including major congenital abnormalities, and a higher risk of spontaneous loss, which might in turn trigger an abortion if the pregnancy cannot be saved. Management of recurrent pregnancy loss[28] or complicated multi-fetal pregnancies (increasingly prevalent with widespread use of assisted reproductive technologies) may also be considered abortion-related conditions. Similarly, uncontrolled hypertension, trauma during pregnancy, seizure disorders and other conditions, all require complex management[29] and may persist beyond the pregnancy, and may result in abortion-related care. These concerns have increasing individual and public health consequence as age at pregnancy[30], body mass index and associated metabolic and cardiovascular abnormalities, Cesarean section rates, multi-fetal pregnancy rates, and use of assisted reproductive technologies[31] have all increased dramatically in recent years.[32] Additionally, in response to more limited access to abortion services, there may be an increase in self-induced abortion, potentially through increased self-administration of misoprostol. Coverage for treatment of complications such as hemorrhage and incomplete abortion in such cases could be denied.

Thus, as an increasing proportion of the market for health benefits becomes subject to exclusionary regulation, coverage for all women can be expected to diminish industry-wide. Moreover, plan administrators, cognizant of the exclusionary regulations under which they operate, may be more likely to broadly interpret the exclusion in order to avoid the sanctions of being barred from the market or losing the right to collect subsidies. Since there is no similar sanction for improper claims denials other than to reinstate the coverage following a successful appeal, the risks all weigh in favor of overly broad interpretation of the exclusion.

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[26] McGann v. H and H Music Company, 946 F. 2d 401 (5th Cir., 1991); Doe v. Mutual of Omaha, 1798 F. 3d 557 (7th Cir, 1999), cert. den. 528 U.S. 1106 (U.S. Jan. 10, 2000).

[27] American College of Obstetricians and Gynecologists, Practice Bulletin, Number 60, *Pregestational Diabetes Mellitus*, March 2005.

[28] American College of Obstetricians and Gynecologists, Practice Bulletin, Number 24, Management of Recurrent Pregnancy Loss, February 2001.

[29] Guidelines for Perinatal Care; American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, pp 175-203, 2008.

[30] Between 1991 and 2001 the number of first births per 1000 women 35 to 39 years of age increased 36% and 70% for women aged 40 –44 years. National Vital Statistics System, annual file; 2003. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5419a5.htm

[31] The reported number of ART cycles has increased from 64,681 to 134,260 ART cycles in 2005, and from 14,507 live-birth deliveries in 1996, to 38,901 in 2005. Centers for Disease Control and Prevention. *2005 Assisted Reproductive Technology (ART) Report: Section 5- ART Trends, 1996-2005*. Atlanta: Centers for Disease Control and Prevention; 2007.

[32] Luke, B., & Brown, M. (2007). Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age. *Human Reproduction, 22*(5), 1264-1272.

Conclusion

One of the great challenges in insurance reform is the unintended consequences of regulation. The Stupak/Pitts Amendment is intended to reach only a specific part of the market. But the cumulative effect of the provision, in combination with existing federal laws governing Medicaid and federal employee health benefits (as well as the law of certain states) inevitably can be expected to move the entire health benefits industry away from its current inclusive coverage norms and toward a new norm of exclusion. The provisions of the legislation, as well as the technical challenges that arise in benefits administration, militate against the creation of a supplemental coverage market. Thus, if the result of national health reform is to move millions of women into a market that operates subject to the exclusion, then it is fair to predict that the entire market for coverage ultimately will be affected as a product tipping point is reached and virtually no supplemental market appears.

In addition, given past experience and the sanctions that arise from a violation, it is reasonable to predict that in interpreting and applying the exclusion, health plan administrators will err on the side of coverage denial. This is because the legal risks associated with coverage determination are all on the side of incorrectly awarding coverage, not erroneously denying it. This balancing of risks can be expected to lead insurers to calibrate coverage determinations in a way that works against women whose medical conditions ultimately lead to an abortion that they never willingly sought.

Dear Representative:

The undersigned organizations strongly urge you to oppose the deceptive "No Taxpayer Funding for Abortion Act" (H.R. 7), a bill designed to fundamentally alter the health insurance market – from a market where abortion coverage is the industry standard to one where abortion coverage is eliminated. H.R. 7 does this by changing the laws that govern both private and public insurance and by twisting the tax code into a tool to take away abortion coverage from women who have it. This bill would not only raise taxes for many women and businesses, but it could also require "rape audits" in which women have to prove to the IRS that they were raped. Ultimately, this bill is designed to deny women the decision whether or not to have an abortion by taking away their insurance coverage.

H.R. 7 twists the tax code into a tool to take away health insurance coverage that women have today. For example, the bill would deny millions of women and families premium assistance tax credits if they purchase a health insurance plan that covers abortion. The bill would force these women to forego a health insurance plan that includes abortion in order to get the premium assistance they need.

H.R. 7 would also raise taxes on small businesses by denying the Small Business Health Tax Credit to businesses that offer health insurance that covers abortion. This credit was created to encourage small businesses to offer health insurance to their employees by making it more affordable. This bill would penalize employers for choosing comprehensive coverage for their employees and their families.

H.R. 7 also has severe consequences for women who experience sexual violence. Incredibly, a rape or incest survivor seeking to include the cost of an abortion in her medical expense deductions or to use tax-advantaged savings to pay for the service may have to provide evidence of the rape or incest if audited by the IRS. Such "rape audits" are a level of government intrusiveness into an individual's private and personal life that is not only unacceptable, but is highly inappropriate.

Finally, H.R. 7 would endanger women's health by eliminating abortion coverage in both the private and public insurance markets. This is particularly true for women underserved by the health care system and women with health problems, even in circumstances where a woman needs an abortion to prevent severe, permanent damage to her health. Because H.R. 7 provides no health exception, it would leave women whose health is seriously threatened by their pregnancies without access to the care their doctors recommend to protect their health.

The legislation would also codify harmful legislative riders that deny women access to public coverage for abortion. These riders include those that deny the District of Columbia the ability to decide whether to use its own local funds to provide abortion coverage and the restriction that bans Medicaid from including abortion coverage, both of which disproportionately affect women of color and low-income women.

In summary, H.R. 7 would deny millions of women the ability to make their own decision about whether to have an abortion by eliminating private and public insurance coverage for it. H.R. 7 is a dangerous bill that jeopardizes women's health by directly banning abortion coverage, by raising taxes on families and small businesses that purchase comprehensive insurance coverage, and by putting women who have survived sexual violence through intrusive tax audits. We strongly urge you to reject this bill.

Sincerely,

Advocates for Youth
American Association of University Women (AAUW)
American Civil Liberties Union
American Public Health Association
American Society for Reproductive Medicine
Asian & Pacific Islander American Health Forum
Association of Reproductive Health Professionals (ARHP)
Black Women's Health Imperative
Catholics for Choice
Center for Reproductive Rights
Choice USA
Feminist Majority
Hadassah, The Women's Zionist Organization of America, Inc.
Jewish Women International
Joint Action Committee for Political Affairs
Methodist Federation for Social Action
NARAL Pro-Choice America
National Abortion Federation
National Asian Pacific American Women's Forum
National Center for Lesbian Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Health
National Organization for Women
National Partnership for Women & Families
National Women's Health Network
National Women's Law Center
People For the American Way
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Connection Action Fund
Population Institute
Raising Women's Voices for the Health Care We Need
Religious Coalition for Reproductive Choice
Religious Institute
Reproductive Health Technologies Project

Sexuality Information and Education Council of the U.S. (SIECUS)
Unitarian Universalist Association
Unitarian Universalist Women's Federation
United Church of Christ, Justice and Witness Ministries

CATHOLICS
FOR
CHOICE

IN GOOD CONSCIENCE

January 8, 2014

US House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution and Civil Justice
H2-362 Ford House Office Building
Washington, DC 20515

Dear Chairman Franks, Ranking Member Nadler and Members of the Subcommittee:

I write to strongly encourage you and your fellow subcommittee members to oppose HR 7, the "No Taxpayer Funding for Abortion Act" sponsored by Representative Chris Smith (R-NJ), which is being heard in subcommittee today. For 40 years, Catholics for Choice has served as a voice for Catholics who believe that our faith's teachings demand that every individual must follow his or her own conscience—and respect others' right to do the same. We stand with the majority of the more than 70 million Catholics in the United States who support access to reproductive healthcare services for themselves and their neighbors and who oppose to this harsh and restrictive bill.

American Catholics, in full accordance with the teachings of our faith, support the right of women and men to follow their own consciences when making critical moral decisions, including decisions about reproductive healthcare. In doing so, Catholics stand with the majority of Americans, who want healthcare decisions to be made by patients, according to their own consciences and in consultation with the medical professionals, loved ones or clergy they choose to involve—not restricted by legislators without knowledge of the personal circumstances involved. Catholics expect our elected officials to stand up for the conscience of every individual, including the millions of women who will suffer if this legislation is allowed to pass.

Nationwide, when Catholic voters considered healthcare reform in 2009, a majority supported health insurance coverage (either public or private) for abortion in most circumstances: when a pregnancy poses a threat to the life of a woman (84 percent); when a pregnancy is due to rape or incest (76 percent); when a pregnancy poses long-term health risks for a woman (73 percent); when test results show a fetus has a severe abnormal condition (66 percent); and whenever a women and her doctor decide it is appropriate (50 percent).[i] In Florida a 2012 state constitutional amendment seeking to impose some of the same restrictions as HR 7 at the state level was soundly defeated by a strong majority (55 percent).[ii] According to exit polling, this included approximately 1 million Florida Catholics.[iii]

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In contrast to this public support for protecting access to these services, HR 7 instead disrespects women's consciences and religious liberty rights, particularly those of lower-income and marginalized women. Contrary to our Catholic social justice tradition, this legislation would permanently impose unreasonable obstacles to safe and legal healthcare for American women who access care through our nation's safety net programs. These include women serving in the military or from military families, women who seek care through the Indian Health Service and women whose insurance is in any way affiliated with the federal government. Placing additional delays and burdens before these women is unjust and demonstrates a cruel disregard for women's human dignity.

In addition to its assault on the dignity and conscience rights of families struggling to make ends meet, this legislation would unjustly hinder the consciences of women who wish to purchase health insurance for comprehensive reproductive healthcare, or to use their private health spending accounts to cover the cost of abortion care, penalizing them simply on the basis of how they receive their insurance. If adopted, HR 7 would also inappropriately interfere with the budgetary autonomy of the District of Columbia and intrude upon the consciences of all women living or seeking medical care in DC.

Most importantly, HR 7 does not answer the problem it purports to resolve. The bill will create more challenges, hurdles and barriers for American women and cost American taxpayers—your constituents—more in uncompensated healthcare costs that result when people cannot access safe, affordable and reliable healthcare when they need it.

This legislation attempts to use our nation's tax and health insurance systems as bludgeons with which to impose the personal views of its sponsor upon all American women. Congress should have no part in compounding the difficulties of women's lives in service of a political agenda and should instead respect each woman's right to follow her conscience, no matter how she accesses healthcare or insurance.

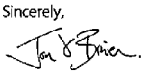
The stance of two witnesses from whom you will hear today is not shared by the majority of Catholics in the United States. The bishops' position—opposing abortion in every instance, even in cases of rape, incest or when an abortion is necessary to preserve a woman's health or life—is shared by fewer than 15 percent of American Catholic voters,[iv] and according to the bishops' own polling, by only 11 percent of the American populace. Those supporting this bill do so because it furthers their ultimate goal of making it impossible for women who need abortions to receive the care they need. The bishops have failed to convince Catholics in the pews of the value of their anti-reproductive health agenda, and are now seeking to use civil law to impose their beliefs upon all people.

Catholics support healthcare that is both accessible and comprehensive. Our Catholic social justice tradition encourages us to advocate for the poor, and our intellectual tradition requires our respect for the conscience-based decisions people make about their lives, including decisions about reproductive health. Our commitment to religious liberty further requires that we respect the right of individuals to follow their own beliefs and practices, without having others' beliefs forced upon them.

As a result, Catholics support policies that enable women to make decisions about their future and the future of their families, each according to her own conscience or faith tradition, and no matter how they receive their insurance. Large majorities of Catholic voters support access to and coverage for abortion—either in private- or government-run health systems. Catholic support for reproductive healthcare is grounded in the core principles of Catholicism, which respect the moral agency of all people and their right to follow their consciences on all matters.

I ask you to appreciate the breadth of Catholic opinion on these issues and not be taken in by false claims about this bill's intent or about what Catholics truly believe. I urge you to oppose HR 7 and to speak out for those who would suffer if this bill's uncompromising agenda is enacted into civil law. Now more than ever, your voice is critical to preserve our freedom.

Sincerely,



Jon O'Brien
President

[I] Belden Russonello & Stewart, "Catholic Voters' Views on Health Care Reform and Reproductive Health Care Services: A National Opinion Survey of Catholic Voters," September 2009.
[II] CNN Politics America's Choice 2012 Election Center, "Florida Amendment 6: No Public Funds for Abortion," http://www.cnn.com/election/2012/results/state/FL/ballot/02.
[III] CNN Politics America's Choice 2012 Election Center, Florida Presidential Election Results http://www.cnn.com/election/2012/results/state/FL/president.
[IV] Belden Russonello & Stewart, "Catholic Voters' Views on Health Care Reform and Reproductive Health Care Services: A National Opinion Survey of Catholic Voters," September 2009.

VINCENT C. GRAY
MAYOR

January 8, 2014

The Honorable Trent Franks
Chairman
House Judiciary Committee Subcommittee on
the Constitution and Civil Justice
2138 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Franks:

I write to express my outrage with legislation that is pending before the House of Representatives, H.R. 7, which contains language extremely offensive to the District of Columbia. H.R. 7 purports to limit the use of taxpayer funds for a constitutionally protected activity, but in truth, it goes much further in its effects on the District of Columbia. The language used in the bill converts the District into a Federal property for the first time in its history. This unprecedented affront to the sovereignty of a local and state government would never be contemplated anywhere else in the United States. Yet, the District is particularly singled out in the bill for such treatment.

This effort to alter the entire status of the District Government is truly beyond the pale. The District of Columbia is comprised of nearly 650,000 people who deserve the same rights as other citizens and residents of their nation. The foundation of our great country is resistance to oppression while promoting freedom and democracy. Given the principles upon which this nation was founded, and America contrives to promote steadfastly world-wide, how can you justify the disparate and disrespectful treatment to which District residents are subjected?

The Constitution guarantees every citizen of age a direct line of communication to the highest levels of our representative government so that their interests are always heard and protected. Our interests are not being protected; they are being stripped from us. As an elected member of the national government, we implore you not to further encroach upon the rights of the people who live in our city.

I cannot urge you strongly enough to remove the nation's capital from this bill. We are not a mere component of the federal government; we are the District of Columbia.

Regards,

Vincent C. Gray

Vincent C. Gray

THE AMERICAN CIVIL LIBERTIES UNION

WRITTEN STATEMENT FOR A HEARING ON

H.R. 7, the No Taxpayer Funding for Abortion Act

TO THE

Subcommittee on the Constitution and Civil Justice
The Committee on the Judiciary, U.S. House of Representatives

January 9, 2014

Laura W. Murphy, Director
ACLU Washington Legislative Office

Sarah Lipton-Lubet, Policy Counsel
ACLU Washington Legislative Office

On behalf of the American Civil Liberties Union (ACLU), a nonpartisan public interest organization dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws, over a half million members, countless additional activists and supporters, and 53 affiliates nationwide, we would like to thank Chairman Franks, Ranking Member Nadler, and members of the Judiciary Committee's Subcommittee on the Constitution and Civil Justice for the opportunity to submit a statement for a hearing on H.R. 7, the so-called No Taxpayer Funding for Abortion Act.

The ACLU opposes H.R. 7 because it further entrenches discriminatory laws that deny abortion care to women who rely on the government for their health care. The bill also extends these unjust prohibitions into the new health care exchanges in an unprecedented attempt to greatly undermine, if not eliminate, the insurance market for abortion, and rewrites the tax code to penalize abortion care. Abortion is basic health care for women and a right protected by the United States Constitution. Congressional interference in women's private decision-making, as embodied in this bill, is wrong, harmful and discriminatory.

1. H.R. 7 Makes Permanent Discriminatory Restrictions on Abortion

The bill currently before the Subcommittee provides that "no funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for any abortion." This language is intended to codify current abortion restrictions on appropriations bills and would do away with Congress' need to consider each year riders that harm women by singling out and excluding abortion from a host of programs that fulfill the government's obligation to provide health care to certain populations. In so doing, the bill would permanently deny millions of women, including Native Americans, Peace Corps volunteers, women eligible for Medicaid, and women in federal prisons, access to abortion care except in very limited circumstances.

The inequity caused by these restrictions is almost as old as the constitutional right to abortion itself and was opposed by the ACLU from the onset. Although Medicaid originally, and appropriately, covered medically necessary abortions, access came under attack in 1976 with the adoption of the Hyde Amendment, which was blocked for nearly a year by an injunction obtained by the ACLU, Planned Parenthood, and the Center for Constitutional Rights, who challenged the law on behalf of a pregnant Medicaid recipient and health care providers in *McRae v Mathews*.[1] Although the Supreme Court would later uphold the Hyde restriction, the

[1] *See* 421 F. Supp. 533 (E.D.N.Y. 1976). The United States Supreme Court vacated the injunction in August 1977 after issuing two decisions that upheld state limitations on the use of public funds for abortion. Three years later, the Court would uphold the constitutionality of the Hyde Amendment. *See* Harris v. McRae, 448 U.S. 297 (1980). The ACLU has also initiated and supported legal battles in state courts to ensure abortion access for low-income women affected by these funding restrictions. *See Access Denied: Origins of the Hyde Amendment and Other Restrictions*

devastating and detrimental impact it has had on low-income women's exercise of a fundamental right cannot be denied. As a result of Hyde and its progeny, women who rely on the government for their health care do not have access to a health care service readily available to women of means. A woman who does not have independent financial resources must scramble to raise the necessary funds, delay receiving abortion care (which can increase the medical risks and costs) and can be left with no choice but to carry to term in circumstances where she is physically, emotionally, mentally and financially unprepared to care for a child.

The Hyde Amendment and similar bans should be repealed—not made into permanent law—because they are discriminatory and harm women's health. If a woman chooses to carry to term, Medicaid (and other federal insurance programs) offers her assistance for the necessary medical care. But if the same woman needs to end her pregnancy, Medicaid (and other federal insurance programs) will not provide coverage for her abortion, even if continuing the pregnancy will harm her health. The government should not discriminate in this way. It should not use its power of the purse to intrude on a woman's decision whether to carry to term or to terminate her pregnancy and selectively withhold benefits because she seeks to exercise her right of reproductive choice in a manner the government disfavors.

Justice Brennan's words about the Hyde Amendment apply equally to the bill currently before the Subcommittee:

> "the Hyde Amendment is a transparent attempt by the Legislative Branch to impose the political majority's judgment of the morally acceptable and socially desirable preference on a sensitive and intimate decision that the Constitution entrusts to the individual. Worse yet, the Hyde Amendment does not foist that majoritarian viewpoint with equal measure upon everyone in our Nation, rich and poor alike; rather, it imposes that viewpoint only upon that segment of our society which, because of its position of political powerlessness, is least able to defend its privacy rights from the encroachments of state-mandated morality."[2]

Indeed, Rep. Henry Hyde was clear about his intent, explaining that "[he] certainly would like to prevent, if [he] could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the…Medicaid bill."[3] With H.R. 7, abortion opponents are pursuing a new, sweeping vehicle.

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on Public Funding for Abortion, AM. CIVIL LIBERTIES UNION (Dec. 1, 1994), https://www.aclu.org/reproductive-freedom/access-denied-origins-hyde-amendment-and-other-restrictions-public-funding-abor

[2] *Harris v McRae*, 448 U.S at 331 (Brennan, J., dissenting).

[3] Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. 12, 12 (2007), *available at* http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.pdf.

2. H.R. 7 Makes Permanent the District of Columbia Abortion Ban, Disenfranchises and Marginalizes D.C. Residents and Denies Women of Color Access to Basic Health Care

Although under current law federal funds may not be used to cover most abortions, states are free to include coverage for abortion in their medical assistance programs if they pay for it themselves. This is true under H.R. 7 as well. The only exception is the District of Columbia.

H.R. 7 makes permanent a provision—lifted by Congress in 2009 but reinstated in 2011—that violates the District's autonomy and forbids it from choosing for itself whether to use its own locally raised non-federal dollars to provide coverage for abortion for its low-income residents.

In 1980, the Supreme Court held that the Hyde Amendment's restriction on federal Medicaid funding of abortions was constitutional despite its devastating impact on low-income women. But at the same time the Court also ruled that state and local governments were still free to pay for abortion for low-income women with their own funds. The Court stated that "a participating state is free, if it so chooses, to include in its Medicaid plan those medically necessary abortions for which federal reimbursement is unavailable."

In recognizing the limited federal role in establishing local health policy, the Supreme Court placed the primary fiscal responsibility for funding abortions with the state legislatures and, in the special case of the District of Columbia, with the District government. In fact, numerous states currently use their own, non-federal funds, to provide medically necessary abortions. Congress does not order New York, California or Arizona not to spend local tax dollars on abortion and it should not do so with the District.

In 1973, Senators and Representatives holding widely divergent political views, also recognized that the citizens of the District of Columbia had been denied the most basic privilege enjoyed by all other Americans – the right to elect those men and women who will control their local governments. They enacted the Home Rule Act to "grant to the inhabitants of the District of Columbia powers of local self-government…and relieve Congress of the burden of legislating upon essentially local District matters."[4] The Home Rule Act was viewed by many as a key civil rights victory for the predominantly African American residents of the District.

With the enactment of home rule, Congress clearly recognized the importance of allowing the District's leadership and residents to exercise control over their municipal affairs. While the scope of the local legislative prerogative has never been precisely defined, the Supreme Court

[4] District of Columbia Self-Government and Governmental Reorganization Act, Pub. L. No. 93-198, 87 Stat. 774, 777 (1973).

has held that our system of limited federalism reserves certain subject areas, including fire prevention, police protection, sanitation, public health, and parks and recreation for state and local decision-making. The provision of services to pregnant women—including abortion care—is clearly a matter of local public health policy intended to be left to the District of Columbia under home rule. Congress should respect the democratic process in the District and respect the choices its residents and leaders make.

As one member of Congress noted, "the government of the District of Columbia representing the wishes of its citizenry must…be able to choose how to spend its revenues collected through property and income taxes and other sources."[5]

The D.C. abortion ban is antithetical to the spirit of the Home Rule Act. Measures such as the abortion ban serve only to disenfranchise and marginalize the District's leaders and residents. Through this provision, non-resident Members of Congress impose their own ideology upon the District's residents and utterly disregard the needs or wishes of the broader community or those directly impacted. Most egregiously, those who seek to negate the will of the District's residents or leaders are not accountable to the people of the District. That which they could not do in their own home districts, they do with impunity against the residents of the District. Measures such as the abortion ban erode and undermine such progress and accentuate the voicelessness of those residing in the District.

3. H.R. 7 Imposes an Abortion Coverage Ban in the New Insurance Exchanges

The Patient Protection and Affordable Care Act (ACA) created new state-based market places called exchanges for individuals and small businesses to buy health insurance. H.R. 7 would revive the so-called Stupak Amendment, rejected by the 111th Congress, which would bar anyone receiving a federal premium assistance credit from buying a private insurance policy that includes abortion coverage on those exchanges.

The Stupak Amendment was—and remains—deeply troubling and alarming for a variety of reasons. It effectively bans abortion coverage on the exchanges. Because the majority of individuals in the exchanges will receive some premium assistance, this provision would mean that no policy sold in these exchanges would include abortion. What is more, a ban on insurance coverage of abortion in the exchanges would have a ripple effect on plans outside the exchanges. This would jeopardize abortion coverage for millions of women.

H.R. 7 is a direct attack on a woman's ability to make personal, private medical decisions and it endangers women's health. The bill makes no exception for women to get the coverage they need even in cases when a woman faces severe and permanent health risks.

[5] *See* 132 Cong. Rec. H4872 (daily ed. July 24, 1986) (statement of Rep. Theodore Weiss (NY)).

4. H.R. 7 Rewrites Tax Law and Policies to Penalize Women in Need of Abortion Care

H.R. 7 rewrites long-standing tax laws to penalize a single, legal, medical procedure: abortion. In particular, it penalizes small businesses and middle-class families, taking away coverage that women already have. It would deny small businesses tax credits designed to make health insurance affordable to all Americans if the insurance they provide includes abortion coverage. According to the Joint Committee on Taxation, that would lead employers to exclude abortion from their plans.[6] H.R. 7 also imposes a tax increase on women who need abortion care by excluding it from health savings accounts, medical savings accounts, and flexible spending arrangements. In addition, individuals could no longer claim the itemized deduction for unreimbursed medical expenses if the medical expense is related to abortion care. That would mean that a woman with serious medical complications who needs an abortion that costs thousands of dollars would not be able to deduct the cost of her abortion; she would have to pay higher taxes than someone with a comparably expensive medical condition, simply because her care required an abortion.

5. Conclusion

Abortion is a legal, medical procedure protected by the United States Constitution. It is also basic health care for women. Yet H.R. 7 attacks women's fundamental right and access to abortion. It first targets women—many of whom are low-income and women of color—who rely on the government for their health care and seeks to permanently deny them coverage for abortion. Then, under the guise of "safeguarding" taxpayer dollars, H.R. 7 advances an aggressive campaign to destabilize the insurance market for abortion coverage. In sum, H.R. 7 intrudes in a woman's private medical decisions and plays politics with women's health. The ACLU opposes this bill.

[6] *No Taxpayer Funding for Abortion Act: Hearing on the Tax-Related Provision of H.R. 3 Before the Subcomm. on Select Revenue Measures of the H. Comm. on Ways and Means*, 112th Cong. (2011) (testimony of Thomas A. Barthold, Chief of Staff, Joint Comm. on Taxation).

ACOG
THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

January 8, 2014

ACOG Position Re: HR 7

The American Congress of Obstetricians and Gynecologists represents more than 57,000 physicians and partners dedicated to improving women's health. In order for women to receive the best health care and disease prevention, they must have access to all medically appropriate, legal medical procedures, regardless of ability to pay. The provision of all medical care must be a medical matter determined by the patient and physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

The No Taxpayer Funding for Abortion Act (HR 7) however would limit women's access to medical care, jeopardizing the health and safety of our patients, and putting government between a physician and a patient. By imposing new tax penalties on millions of families and small businesses, the likely consequence would be to take away the health insurance coverage that women have today. By not allowing for a health exception, HR 7 would leave women whose health is seriously threatened by their pregnancies with limited access to the care their doctors recommend to protect their health. The legislation would also codify harmful riders that deny low-income women access to abortion care.

If you have any questions, please contact Nevena Minor, Federal Affairs Director at nminor@acog.org or 202-314-2322.

CENTER FOR REPRODUCTIVE RIGHTS

Center for Reproductive Rights
Testimony

Before the Subcommittee on the Constitution
Committee on the Judiciary
United States House of Representatives

January 10, 2014

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill. Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights.

We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world in which every woman participates with full dignity as an equal member of society.

An essential step to realizing this vision is to ensure that every woman has access to comprehensive health care, including abortion care, regardless of her income or source of insurance. In contrast, H.R. 7 is a sweeping ban on abortion coverage representing yet another mean-spirited attempt to interfere with a woman's personal decision-making, one that will fall hardest on women who are already struggling to get by. Congress should emphatically reject this extreme proposal.

H.R. 7 Would Make Current Denials of Coverage More Intractable

H.R.7 would punish the many women who get their health care or coverage through the federal government. Federal employees, women enrolled in Medicaid, military servicewomen, Peace Corps volunteers and many others are currently denied insurance coverage for abortion by a range of federal policies. Most of these restrictions have no home in the U.S. Code; instead,

they are re-enacted each year in annual appropriations bills. H.R. 7 would make these damaging restrictions even more intractable by enshrining them in permanent law.

Although the damage that would be done by H.R. 7 extends far beyond the codification of these discriminatory policies, this effect alone would be tragic because these denials of coverage have a tremendously harmful impact on the women they target. For example, as our 2010 report documents, the ban on abortion coverage for women enrolled in Medicaid has forced women to sell or pawn their possessions, forgo paying bills, get evicted for failure to pay rent, go hungry, and suffer the fear of not knowing whether they will be able to access the care they need.[i] The struggle to raise funds forces many women to delay obtaining abortion services and others to carry unwanted pregnancies to term. In other cases, as we know from decades of experience prior to *Roe v. Wade* and from places throughout the world where abortion is banned, many women who want to end their pregnancies but are faced with seemingly insurmountable obstacles will put their health and life at risk seeking an unsafe abortion.

These restrictions – although most disastrous for women with the least means – know no socio-economic boundaries. For example, restrictions on coverage for federal employees cruelly compounded the agony of a woman who terminated a wanted pregnancy because she learned that her fetus had no brain and no chance of survival. After making that profoundly difficult decision, she discovered that her federal insurance did not cover the procedure. In the midst of her grief, she was handed a $9,000 bill.[ii] H.R. 7 guarantees that more women will suffer similar injustices.

H.R. 7 Is an Extreme Attempt to Extend Denials of Coverage into the Private Market

H.R. 7 is a radically broad bill that creates burdensome new tax penalties designed to make coverage of abortion unavailable through private health insurance policies, stripping away coverage that millions of women currently have, including insurance paid for with private dollars or provided by employers in the new state marketplaces.

a. The bill would effectively ban abortion coverage in the new state marketplaces, denying comprehensive health insurance to women using their own funds to purchase coverage

On the surface – and consistent with other attacks on women's access to abortion services – H.R. 7 targets low to moderate income families eligible for premium assistance credits in the new state marketplaces. Under the Patient Protection and Affordable Care Act (PPACA),

insurance issuers may offer plans that cover abortion in the new state marketplaces if they segregate funds paid for abortion coverage from the funds paid for all other coverage – an onerous administrative requirement that already stigmatizes abortion by treating it differently from other health care. Yet now, by banning premium assistance credits from being applied to any plan that includes abortion, H.R. 7 represents a new effort to drastically expand an ideological agenda into the private market and completely eliminate abortion coverage from state marketplaces altogether.

The effect is that H.R. 7 not only targets low and moderate income women, but *all* women purchasing insurance in the state marketplaces, including those paying for coverage entirely with private dollars. Because a great majority of individuals in the marketplaces are eligible for premium assistance, H.R. 7 would essentially eliminate comprehensive plans that include abortion coverage. Insurers are unlikely to offer a product that a majority of potential customers are barred from purchasing. Thus the ban will impact everyone participating in the marketplaces, including millions of unsubsidized individuals and small business employees. Over time, these restrictions will affect more and more women, as the marketplaces are designed to grow over time to encompass the large-employer market.[iii]

Furthermore, while the bill offers up the ability for women eligible for premium assistance credits to purchase separate abortion coverage, there is little evidence that such policies will be made available by insurers. This is largely because insurance does not work on an a la carte basis. Consumers cannot anticipate all of their future health care needs and a system of insurance coverage would be ineffective if consumers were required to tailor their coverage in advance based on unforeseen, unexpected needs. Moreover, if such policies with separate coverage for abortion did exist, women eligible for assistance in purchasing health care insurance are very unlikely to be able to afford a second insurance policy on their own.

b. The Bill Punishes Small Businesses for Offering Comprehensive Coverage

H.R. 7 would further restrict the private market by creating tax penalties for small businesses that offer comprehensive coverage by denying the small employer health insurance tax credit for any employer contributions to plans that include abortion coverage.

Small businesses are essential to economic growth. Those health insurance tax credits are critical not only to stemming the escalation in health care costs broadly but to making health care

coverage affordable for American entrepreneurs and their businesses. Yet instead of rewarding small businesses, this bill would punish them in ever more innovative ways. H.R.7 would greatly complicate and confuse this community's ability to provide insurance coverage.

The bill imposes a tough assignment on the 4 million small businesses eligible for the credit – to dig through the details of its health insurance policy to determine if it covers abortion. Whether a health care plan covers abortion care is far from simple to figure out, as coverage could occur in many categories, from prescription drugs to outpatient surgery to maternity care that includes unforeseen complications. Indeed, many plan managers do not know whether abortion is covered, and will have to spend considerable time trying to figure it out. And if their plan does include abortion coverage, which is likely given that – absent political interference - most employer-sponsored plans do,[iv] they will either have to give up the tax credit or spend more time and money finding a new plan, detrimental to both the employer and its employees. In the end, this provision in H.R. 7 will have only served the purpose of undermining employees' access to comprehensive health insurance.

This bill forces small business owners to pay a price because some in Congress have decided to rewrite the tax code to suit their own narrow ideological goals – goals that have nothing to do with sustaining, growing, and supporting small businesses.

c. The Bill Punishes Individuals Using their Own Money to Pay for Abortion Care

In addition to the disincentives intended to prevent women from accessing insurance that could cover abortion, H.R. 7 also seeks to punish and shame women who pay directly for abortion care. The bill would eliminates tax deductions for medical expenses related to abortion and bar individuals from using their own money set aside in health flexible spending accounts (FSAs) or other tax preferred savings accounts to cover abortion related costs. Such provisions make clear the true intent of this bill – not to simply "prevent taxpayer funding of abortion" but to eliminate women's access to this constitutionally protected service altogether.

H.R. 7 Would Force Tax Auditors and Employers to Intrude into the Most Personal, Private Aspects of Women's Lives.

The tax penalties imposed by H.R. 7 would be subject to narrow exceptions for pregnancies that are the result of rape, incest, complications arising from abortion, or where the woman's life is endangered.

CENTER FOR REPRODUCTIVE RIGHTS

Essentially, H.R. 7 calls on the IRS to conduct rape audits.[v] As Thomas A. Barthold, Chief of Staff of the Joint Committee on Taxation, testified in 2011, the burden of proof regarding whether or not an abortion occurred within the narrow confines of one of those exceptions will fall on the taxpayer.[vi] This means that women will be required to keep records, and to open up those records – and their highly personal traumatic experiences – to the probing investigations of IRS agents. According to a former longtime IRS official, "on audit [she] would have to demonstrate or prove, ideally by contemporaneous written documentation, that it was incest, or rape, or [her] life was in danger . . .[i]t would be fairly intrusive for the woman."[vii]

The case of incest is even more difficult. H.R. 7 could require the taxpayer (which could include an abusive father) to substantiate that the abortion was the result of abuse, creating an untenable and volatile situation for a family already in difficult and painful circumstances. To make matters worse, in addition to policing rape and incest, H.R. 7 would turn IRS officials into amateur physicians, requiring them to determine which dangerous conditions should qualify as life endangering under the bill.

Needless to say, such determinations – for practical, medical and emotional reasons – are far beyond the expertise and training of the typical IRS auditor, in addition to being outrageous and inappropriate. This alone constitutes substantial evidence that H.R. 7 works a serious abuse of the tax code in the service of ideology.

In addition to inviting the IRS into the most personal aspects of women's lives, H.R. 7 could require a woman to report an abortion to her employer. As noted above, H.R. 7 provides that abortion services must be excluded from health FSAs, which otherwise allow individuals to reduce their cash compensation and set aside funds for medical expenses. When this provision was proposed in 2011, the Joint Committee on Taxation reported that it is likely that the IRS would require that any amount paid for abortion services "be reported on the employee's Form W-2 . . . as wages, tips and other compensation..."[viii] H.R. 7 now extends this restriction to other tax-preferred savings accounts (health savings accounts or "HSAs" and Archer medical savings accounts (Archer MSAs")). H.R. 7 creates a big brother regime in which women's private medical decisions are forced into public view, exposed to myriad parties who could use that information to the woman's detriment.

CENTER FOR REPRODUCTIVE RIGHTS

H.R. 7 Unfairly Targets Women in the District of Columbia, Denying Their Reproductive Freedom

H.R. 7 defines the District of Columbia city government as part of the federal government for the purposes of abortion, thus permanently prohibiting the District from spending its local funds on abortion services for low-income women, regardless of what DC taxpayers want. This audacious provision denies the District its right to self-government while jeopardizing the health and safety of the District's female residents, particularly low-income women. For no clear reason other than to deny this group of women their reproductive freedom, the bill singles out the District of Columbia in a way that it does not for any other state or locality. This is an unwarranted and unfair attack on one group of women and one jurisdiction.

Conclusion: Congress Should Reject this Harmful Bill

The Center for Reproductive Rights urges Congress to reject this dangerous and extreme legislation.

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[i] Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 28-29 (2010), *available at* http://reproductiverights.org/en/feature/whose-choice-how-the-hyde-amendment-harms-poor-women.
[ii] Statement of DJ Feldman on Harmful Impact of Abortion Coverage Restrictions, Nov. 16, 2009 *at* http://reproductiverights.org/en/feature/no-abortion-ban-statement-by-dj.
[iii] PPACA § 1312(f)(2)(B)(i).
[iv] *See* Guttmacher Institute, *Memo on Private Insurance Coverage of Abortion* (Jan. 2010), *available at* http://www.guttmacher.org/media/inthenews/2011/01/19/index.html.
[v] *Hearing on the Tax-Related Provision of H.R. 3: Hearing Before the Subcomm. on Select Revenue Measures of the H. Comm. on Ways and Means,* 112th Cong. (2011) (oral testimony of Thomas A. Barthold, Chief of Staff, Joint Comm. on Taxation), *available at* http://waysandmeans.house.gov/news/documentsingle.aspx?DocumentID=267274 (last visited Jan. 9, 2014). *See also* Nick Baumann, *GOP Bill Would Force IRS to Conduct Abortion Audits*, MOTHER JONES, Mar. 18, 2011, *available at* http://www.motherjones.com/politics/2011/03/gop-bill-irs-abortion-audits (last visited Jan. 8, 2014).
[vi] *See id.*
[vii] *See* Baumann, *supra* note vi.
[viii] Joint Committee on Taxation, *Description of H.R. 1232,* (JCX-21-11), 12-13, March 29, 2011.

Testimony of Vicki Saporta, President and CEO of the
National Abortion Federation
Submitted to the House Judiciary Subcommittee on the Constitution
Hearing on H.R. 7, the "No Taxpayer Funding for Abortion Act"
January 9, 2014

The National Abortion Federation (NAF) is the professional association of abortion providers in North America. Our members include private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals who together care for more than half the women who choose abortion in the U.S. and Canada each year. Our members also include public hospitals and both public and private clinics in Mexico City, and private clinics in Colombia.

The mission of the National Abortion Federation is to ensure that abortion care is safe, legal, and accessible, which promotes health and justice for women. Since 1977, we have actively opposed funding bans and restrictions on access to abortion care at the federal and state levels. We have also provided direct support to women seeking accurate information about pregnancy options and abortion care.

As President and CEO of NAF, I'm in a unique position to comment on this bill. NAF hears from tens of thousands of women every year who would be harmed by the unjust policies contained in H.R. 7. Every day we hear from women facing considerable barriers to accessing the abortion care they need, often due to existing funding bans. These women are desperate to make the best decisions for themselves and their families, but frequently cannot – because of law, because of circumstances, and because of the decisions of politicians who think they know better.

In this already difficult climate, H.R. 7 would implement insurmountable obstacles for countless women needing to access abortion care, and I have no doubt that this is the bill's sole intention. Not only does this bill burden low-income women, a perennial target for anti-choice lawmakers, but it also targets every woman dependent on the private insurance market for health care. It is an unprecedented interference in the lives of women and their families.

H.R. 7 Would Interfere in Women's Private Health Care Decisions

The "No Taxpayer Funding for Abortion Act" is a misleading and dangerous bill that aims to dismantle insurance coverage for abortion care. Its effect would range from burdensome to tragic, and would be felt by millions of women and families. The Smith Bill would drastically alter the insurance landscape with two sweeping changes. First, through a regulation similar to the defeated Stupak-Pitts amendment, it would render any state exchange health plan that covers abortion unsustainable. Second, by banning health care related tax deductions for private

insurance plans that include abortion care, this bill would penalize individuals and small businesses for keeping plans that offer comprehensive coverage. These two regulations would have a dramatic effect on the insurance market, where historically the majority of private health insurance plans cover abortion care.

As the professional association of abortion providers, we know that serious health conditions or life endangering situations can arise during pregnancy that make abortion care a woman's best option. But, after dismantling the current insurance market, H.R. 7 could create a market that only offers coverage for abortion care in the narrow exceptions of rape, incest, and life endangerment. A woman's health or well-being is not a consideration in Representative Smith's bill.

H.R. 7 would affect women like Carly,[i] who could be forced to choose between financial ruin and her health and well-being. Carly was suffering from kidney disease and was in a great deal of pain. She was unable to work, and was having trouble providing for her two children. When she became pregnant, she made the decision to have an abortion so that she could have her kidney removed and begin the road to recovery. Carly knew that carrying her pregnancy to term would create many more health problems, and would leave her unable to care for her family. A lack of coverage likely to result from H.R. 7 would mean that Carly could not afford the care she needed.

Further, the tax penalties in H.R. 7 would deter small businesses from choosing the most comprehensive reproductive health coverage for their employees, with devastating health consequences for small business employees and their families. We recently heard from Samantha,[ii] who was seriously injured in a car accident, which left her unable to walk. Samantha was pregnant and carrying the pregnancy to term was not an option for her. Without coverage from her employer's health plan, she would not have been able to afford the abortion care she needed. Under H.R. 7, women like Samantha could lose their coverage.

H.R. 7 Contains Hyde-Like Restrictions on Federal Funding That Jeopardize Women's Health

This bill also contains a federal funding ban targeting low-income women who rely on the federal government for their health care. It would codify the Hyde Amendment, which since 1976 has prohibited the use of federal funds for most abortion care. The Hyde Amendment is a harmful policy that unfairly denies comprehensive health care and autonomy to our nation's low-income women. Women should not be forced to sacrifice basic necessities, including rent, food, or child care, in order to obtain the necessary funds to have an abortion. Nor should they further risk their own health by delaying their abortion care until later in their pregnancy while they try to raise funds.

The restrictions imposed by federal funding bans unfairly jeopardize the health and well-being of low-income women and their families. Women in desperate situations may resort to self-inducing an abortion or obtaining unsafe procedures from untrained practitioners. Federal funding bans also harm women's health by denying coverage for abortion care in cases where women have serious physical or mental health concerns.

The Hyde amendment denied Reagan[iii] coverage for her abortion care. When Reagan discovered she was pregnant her doctor told her that the medication she took to control her seizures was likely to cause fetal anomalies. Reagan decided very early in her pregnancy that an abortion was the best course of treatment. However, Medicaid would not cover her abortion care. Fortunately, Reagan worked with a clinic, which helped raise the funds so she could have an abortion.

Federal funding bans have a disproportionate effect on women of color, who are more likely to live below the poverty line and become eligible for government health care. According to census data, 25.5 percent of African Americans, 25 percent of Latinas, 67 percent of Laotians, 66 percent of Hmong, 47 percent of Cambodians, and 27 percent of Native Americans and Alaskan Natives are living below the poverty level, compared to only 10.4 percent of whites.[iv]

The sweeping ban contained in this bill would also deny coverage for abortion care for federal employees, servicewomen, and Peace Corps volunteers. The employees, volunteers, soldiers, airwomen, marines, and sailors who serve our country, and their families, do not deserve to be denied access to comprehensive reproductive health care because of the political posturing of members of Congress.

The National Abortion Federation has worked on equity for servicewomen for more than a decade, and we've heard from many women who are affected by this ban. Women like Jane,[v] an active duty servicewoman stationed in Afghanistan whose first priority is serving her country, not starting a family. Unfortunately, her doctors failed to tell her that her government-issued malaria pills would interfere with her birth control pills. As a result, Jane, who is stationed with her husband, became pregnant. She should not be forced to end her front-line duty in Afghanistan and her military career, but that's exactly what could happen under H.R. 7.

H.R. 7 Restricts DC from Using Its Own Locally Raised Funds

H.R. 7 would also permanently prohibit the District of Columbia from using its own locally raised funds to provide abortion care. This is a violation of DC's right to self government, and detrimental to the health care needs of women who live in the District of Columbia. When the federal ban was temporarily lifted in recent years, DC's own civic representatives chose to provide abortion coverage for Medicaid eligible women. Women like Allison,[vi] who is a single mother of four, living in the District of Columbia. Unfortunately, when Allison learned she was pregnant, the federal restriction was back in place and the District of Columbia, once able to help her, was barred by Congress from offering her aid. Allison was enrolled in Medicaid and only had $20 to her name. After exhausting all of her options, she was fortunately able to get support from a local fund, and the clinic agreed to discount the cost of her procedure so she could access the abortion care she needed.

NAF Urges You to Vote Against this Extreme and Harmful Bill

A ban this widespread would deny millions of women the reproductive health care coverage they need to make the best decisions for themselves and their families. We urge you to reject this dangerous bill.

[i] Name changed to protect privacy.
[ii] Name changed to protect privacy.
[iii] Name changed to protect privacy.
[iv] *See* Suzanne Macartney et al, "Poverty Rates for Selected Detailed Race and Hispanic Groups by State and Place: 2007–2011" (Washington: United States Census Bureau, 2013), and National Asian Pacific American Women's Forum Fact Sheet "Hyde: Thirty Years is Enough" (2008).
[v] Name changed to protect privacy.
[vi] Name changed to protect privacy.

January 10, 2014

The Honorable Jerrold Nadler, Ranking Member
Judiciary Subcommittee on the Constitution and Civil Justice
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Nadler:

Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in opposition to H.R. 7, the No Taxpayer Funding for Abortion Act, on which a hearing was held before the Subcommittee on the Constitution and Civil Justice on January 9, 2014.

Through its work as an independent, not-for-profit organization focusing on reproductive health research, policy analysis and public education in the United States and internationally, the Guttmacher Institute has developed and analyzed a great deal of information on public- and private-sector abortion insurance coverage, the implications for the health and well-being of women and their families of insurance coverage or the lack thereof, and the relationship between insurance coverage and abortion incidence. Many of the Institute's research findings, along with key research findings of other experts in the field, are addressed in an article directly relevant to H.R. 7: "Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest" from the *Guttmacher Policy Review*, attached for inclusion in the record.

A primary purpose of H.R. 7 is to write into permanent law the Hyde Amendment, which has been incorporated into annual appropriations law since 1976 and sharply limits abortion coverage (currently to cases of life endangerment, rape and incest) under Medicaid, the joint federal-state health insurance program for the nation's lowest-income citizens. H.R. 7 would also make permanent the Hyde amendment's so-called progeny, a series of policies that similarly restrict abortion coverage or services for other groups of women dependent on the government for their health insurance or health care, ranging from women in federal prisons to women in the U.S. armed forces.

Moreover, HR 7 would extend the harms of the Hyde amendment and its progeny further by seeking, under the disingenuous "no taxpayer funding" label, to eliminate abortion coverage in the private health insurance market too. The effect of this new incursion would be to take abortion coverage away from many women for whom this has been a standard health insurance benefit for a long time.

As discussed in "Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest," the Hyde Amendment is a pernicious law that explicitly targets the poorest and most vulnerable women. A number of studies conducted over the last three decades have assessed the impact of the Hyde amendment's near-ban on Medicaid insurance coverage of abortion. Research shows that one in four Medicaid enrollees who want to terminate an unwanted pregnancy are unable to do so because they can't come up with the necessary funds. As the all-important Medicaid expansions take effect this year in 25 states and the District of Columbia, it is a perverse irony that one result is that even more women are

now subject to the Hyde amendment. Roughly 9.7 million women of reproductive-age were enrolled in Medicaid as of 2012; millions more will qualify as states opt to raise Medicaid income eligibility to 138% of the federal poverty line.

Many women who are purchasing private insurance coverage on the new health insurance exchanges may well be ensnared by Hyde-like restrictions as well. Under the Affordable Care Act, federal subsidy dollars for individuals purchasing plans on the health insurance marketplaces may not be used to pay for abortion coverage, except in cases of life endangerment, rape or incest. As of 2012, roughly 37.5 million women aged 15–44, accounting for 60% of women of reproductive age, were privately insured.

I would like to address a point on which Guttmacher research is frequently invoked and misrepresented. While one in four Medicaid enrollees who would have an abortion if it were covered under Medicaid is unable to do so, it does not follow that restoration of federal Medicaid coverage would result in a commensurate increase in the incidence of abortion nationwide. This is because only a small proportion of women are enrolled in Medicaid in any state, and because 17 states, including several of the nation's most populous, are among those that use their own money to pay for abortion services for poor women.

Accordingly, the research shows that repealing the federal Hyde Amendment would translate into an estimated 5% rise in the total number of abortions in the group of states in which funding is currently restricted—and a only a 2.5% increase in the total number of abortions performed nationwide.

In conclusion, both for public and private insurance coverage of abortion, this bill ignores the reality that abortion is a legal, constitutionally protected and medically appropriate health care service. The Hyde Amendment and its progeny should be repealed, not reinforced, and certainly not expanded further into the private insurance market.

Thank you for the opportunity to provide these comments.

Sincerely,

Susan A. Cohen

Susan Cohen
Acting Vice President for Public Policy

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Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest

By Heather D. Boonstra

In recent years, antiabortion activists have made significant political and legislative gains at the federal and state levels. In at least one way, however, they may be overplaying their hand, by pressing for nearly absolute bans on abortion, even in instances of rape. In June, controversy erupted during debate on a bill to ban nearly all abortions late in pregnancy. The bill's author, Judiciary Subcommittee on the Constitution Chairman Trent Franks (R-AZ), defended the lack of a rape exception in the original bill by asserting that "the incidences of rape resulting in pregnancy are very low."[1] Within hours of Franks' comments, the Internet lit up with comparisons to Todd Akin and Richard Mourdock. In August 2012, leading up to the fall elections, Akin—the Republican Senate nominee from Missouri—provoked ire across the political spectrum when he suggested that exceptions for abortion in cases of rape were unnecessary because in the case of a "legitimate rape," a woman's body could "shut the whole thing down."[2] Two months later, Mourdock—the Republican Senate candidate from Indiana—drew national opposition for having said in a debate that he believed pregnancies resulting from rape were a "gift from God" and should not be terminated.[3] These remarks and their aftermath damaged the Republican Party on the national stage, which likely helped Democrats win several seats and keep control of the Senate.

For abortion rights advocates, these incendiary comments provided an opening. In December 2012, advocates were able to mobilize support for a small but significant change in the Defense Department authorization bill for 2013. The change broadened coverage for abortion services for servicewomen and military dependents to include cases of rape or incest—beyond only when the woman's life would be threatened by continuing her pregnancy. This breakthrough brought federal abortion policy for U.S. servicewomen into line with the Hyde amendment, which provides for the use of federal funds for abortion under Medicaid only in these three circumstances. It also has provided momentum for softening the antiabortion law that affects Peace Corps volunteers and for revisiting the interpretation of the decades-old antiabortion law governing aid to developing countries (see related article, page 9).

These developments represent steps in the right direction, yet the pursuit of this incremental approach risks sidelining a critical but daunting task: confronting the injustice of the Hyde amendment itself. The practical impact of restrictions on abortion coverage under Medicaid are real and can be measured both in the sacrifices of women struggling to find another source of funds for an abortion, and in the unplanned and often unwanted births to those unable to do so. Achieving true equity in access to abortion coverage for low-income women goes to the heart of what it means to possess a right to safe and legal abortion that is not merely theoretical, but also meaningful.

In the Beginning

Overturning *Roe v. Wade*—and going further to make abortion illegal nationwide—has been the antiabortion movement's ultimate goal for four decades. In the years immediately following the 1973 Supreme Court decision, the primary focus of antiabortion activists' public and legislative agenda was on an ultimately futile effort to pass a

"human life amendment" to the U.S. Constitution that would establish personhood "from the moment of fertilization." At the same time, antiabortion activists threw their support behind efforts to limit access to abortion care. In 1973, Congress passed the Helms amendment, which banned the use of U.S. foreign assistance to pay for the "performance of abortion as a method of family planning." The passage of the Helms amendment laid the groundwork for a similar domestic measure championed by the late Rep. Henry Hyde (R-IL) a few years later.

The first version of the Hyde amendment, passed in 1976, banned the use of federal funds for abortion services, except in cases where the life of the woman was at stake, for all programs administered by the Department of Health, Education and Welfare (now the Department of Health and Human Services). The measure had the effect of banning abortion coverage for women insured by the Medicaid program.

During debate over the measure, Hyde himself acknowledged the blatantly discriminatory nature of the proposal. He argued that abortion should be included in the category of luxuries available to wealthy women at their own expense, but not to the poor with public funding: "If rich women want to enjoy their high-priced vices, that is their responsibility…that is fine, but not at the taxpayers' expense."[4] This argument prevailed in Congress in 1977, when Congress readdressed the Hyde amendment. Hyde told his colleagues, "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the… Medicaid bill."[5]

The ban on public funding for abortion was hotly debated through the rest of the 1970s, and the back and forth between the House and the Senate threatened to shut the government down more than once during that time. Meanwhile, abortion rights defenders challenged the Hyde amendment's constitutionality in the federal courts. In 1980, the U.S. Supreme Court ruled in the landmark case of *Harris v. McRae* that the Hyde amendment is constitutional. The court held that the funding restriction did not impinge on the right to seek abortion, writing that "a woman's freedom of choice [does not carry] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices." The federal government could choose to encourage childbirth over abortion (by providing coverage for the costs associated with childbirth, while banning coverage for abortion) because childbearing was "rationally related to the legitimate governmental objective of protecting potential life."

The current version of the Hyde amendment, in effect since 1997, bans federal funding for abortion, except in cases of rape, incest or where a woman's life is threatened by "a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself." Because Medicaid is a joint federal-state program, states may use their own funds to provide abortion coverage for Medicaid recipients, and 17 states currently do so—some voluntarily and some by court order (see map).[6]

PUBLIC COVERAGE FOR ABORTION

Seventeen states use their own revenues to pay for abortion coverage for women enrolled in Medicaid; the remaining states cover abortion only in limited circumstances, usually following the standard set by the Hyde amendment.

Source: reference 6.

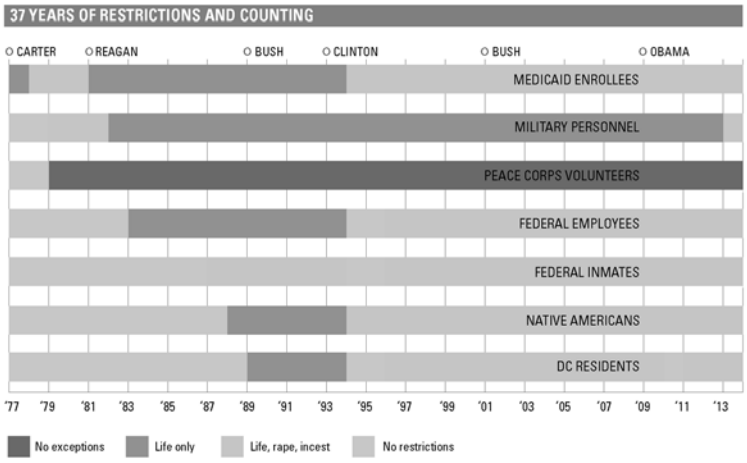
Hyde's Progeny

Over the last several decades, Congress has enacted a series of policies that similarly restrict abortion coverage or services for other groups of women dependent on the government for their health insurance or health care, including federal employees, military personnel, federal prison inmates, poor residents of the District of Columbia and Native American women (see chart).

The issue over federal involvement in abortion coverage went largely dormant until the debate over health care reform got underway in the summer of 2009. Early on, President Obama and prochoice leaders in Congress sought to tamp down the brewing controversy by asserting that health care reform should not be the vehicle for reopening the abortion debate. Instead, they asserted that the status quo should apply, which itself spawned another clash over exactly what that meant.

Abortion rights advocates reluctantly agreed to leave intact a ban on the direct use of federal funds for abortion coverage, per the Hyde amendment, and to apply that ban to proposed federal subsidies for private health insurance. Abortion foes, by contrast, exploited this new opening to stretch radically the concept of what constitutes government funding. Indeed, they came close to winning the inclusion of the so-called Stupak amendment, named after antiabortion Rep. Bart Stupak (D-MI), which would have banned private insurers from covering abortion for anyone in plans where any individual subscriber receives a federal subsidy under the act.

Ultimately, the Affordable Care Act (ACA), signed into law in March 2010, reflects a compromise that nonetheless created a new precedent for federal interference in abortion coverage in the private insurance market. Under the final compromise, federal funds—in this case, subsidy dollars for individuals purchasing plans on the health insurance marketplaces scheduled to be operational this fall—may not be used to pay for abortion coverage, except in cases of life endangerment, rape or incest. But insurers, at least in theory, still may offer plans that include abortion coverage,



Note: For Medicaid enrollees in FY 1978–1979 and for military personnel in FY 1979, the law also included an exception for severe and long-lasting physical health damage.

so long as that portion of the coverage is paid for by the subscriber, not with federal funds.

In practice, however, the abortion provision in the ACA establishes some potentially high hurdles that could severely limit women's access to plans that cover abortion. To ensure the segregation of funds, insurance companies offering plans that include abortion coverage for individuals with subsidized coverage will need to estimate the cost of the coverage and issue a bill that separates this cost from the costs of all other coverage. Insurance companies will also need to maintain separate accounts and submit a plan to the state insurance commissioner that details a process to ensure that the payments for abortion coverage never mix with federal funds.[7]

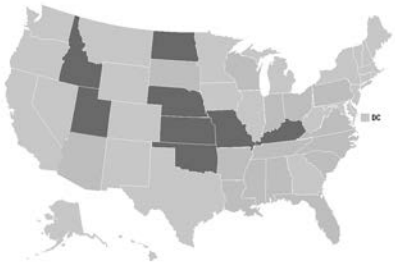
In addition, the final compromise invites states to prohibit abortion coverage in private plans outright—and many have done so. Twenty-three states have laws essentially banning abortion coverage in plans that will be offered through the health insurance marketplaces, including eight states that ban insurance coverage of abortion more broadly in all private insurance plans regulated by the state (see map).[8] And, just like the federal government, 18 states have banned abortion coverage in insurance plans for public employees.

Insurance Coverage Matters

It is too early to know what the impact will be of these new restrictions on private insurance coverage of abortion. However, some 35 years after the initial passage of the Hyde amendment, there is a strong body of evidence on the impact of denying insurance coverage of abortion to low-income women insured through Medicaid. A 2009 literature review published by the Guttmacher Institute identified 38 studies published between 1979 and 2008 that analyzed the impact of the Hyde amendment on a range of outcomes.[9] The review concludes that one in four women with Medicaid coverage subject to the Hyde amendment who seek an abortion are unable to obtain one due to the lack of coverage. This conclusion was based on studies from five states that compared the ratio of abortions to births before and after funding ended. The study with the best design examined abortion and birth rates in North Carolina, where a state abortion fund ran out of money before the end of the fiscal year on several occasions between 1978 and 1993.[10] This study found that 37% of women who would have had an abortion if Medicaid coverage were available carried their pregnancy to term during the periods when funding was unavailable. (A key caveat worth emphasizing, however, is that restoration of federal Medicaid coverage would not result in a commensurate increase in the incidence of abortion nationwide, as leading antiabortion activists incorrectly have concluded; see box.)

PRIVATE COVERAGE FOR ABORTION

Eight states have laws banning abortion coverage in all private health plans, including the new plans offered in the health insurance marketplaces; 15 additional states have bans that are limited to marketplace plans.



Source: reference 8.

American women who are denied an abortion struggle more financially than women who undergo the procedure, according to a study by researchers at the University of California, San Francisco, presented at the 2012 meeting of the American Public Health Association.[14] The study was based on data on more than 800 women seeking abortions at 30 U.S. facilities, comparing women who received an abortion and women who were turned away because they requested an abortion beyond the provider's gestational age limit. One year later, the women denied an abortion were less likely than the women who received an abortion to be working full time and more likely to be receiving public assistance and

Insurance Coverage and Abortion Incidence

In March 2010, Rep. Michele Bachmann (R-MN) warned that insurance coverage of abortion under health care reform would result in a huge jump in the number of abortions in the United States.[11] "We know from the Alan Guttmacher Institute that if there is taxpayer funding of abortion, there will be 30% more abortions," she said at a press conference. Given that an estimated 1.2 million abortions are performed in the United States each year, a 30% increase would mean an additional 360,000 abortions.

Guttmacher studies and those from other researchers on the impact of the Hyde amendment do indeed conclude that denial of abortion insurance coverage under Medicaid impedes a sizable minority of America's poorest women from obtaining the procedure. But the claim that restoration of abortion coverage would result in a substantial increase in the nationwide incidence of abortion is not supported by the research.

This is because only a small proportion of women are enrolled in Medicaid in any state and, therefore, affected by the Hyde amendment. It is also because 17 states—including several of the nation's most populous, such as California and New York—already use their own money to pay for abortion services for poor women. Accordingly, lifting the Medicaid restrictions on abortion coverage would translate into an estimated 5% rise in the total number of abortions in the group of states in which funding is currently restricted.[12] The national impact of repealing the Hyde amendment would be even smaller: The number of abortions among Medicaid-eligible women nationwide would be expected to increase by approximately 33,000 if the Hyde amendment were to be repealed—or only a 2.5% increase in the number of abortions performed nationwide.

Moreover, extrapolating from Guttmacher's Medicaid findings to assert that coverage in the private insurance market is strongly linked to abortion incidence is entirely illegitimate. It is true that, under health care reform, millions of individuals who would otherwise be uninsured are expected to have coverage. Many private insurers, however, will simply decline to sell policies covering abortion on the health insurance marketplaces. Even for those insurers that do offer abortion coverage, there is little reason to think that such coverage would allow sizable numbers of women to obtain abortions that they cannot already afford today. The lack of abortion coverage is not nearly the impediment for higher income women as it is for low-income women. Therefore, the availability of coverage in private insurance plans, while important at the individual level, cannot be expected to substantially increase the overall numbers of abortions. In fact, in Massachusetts—a state that enacted its own universal health care plan in 2006 and provides abortion coverage for individuals with subsidized private coverage and for Medicaid enrollees—the number of abortions actually declined by 1.5% between 2006 and 2008, even as the insured population grew by nearly 6% over the same period.[13]

living below the federal poverty line—despite the fact that there were no economic differences between the two groups a year earlier.

Importantly, most low-income women with Medicaid coverage subject to the Hyde amendment manage to obtain an abortion,[9] notwithstanding the lack of coverage—a fact that speaks to women's determination not to bear a child or another child they feel unprepared to care for. Doing so, however, often comes at a considerable price to themselves and their families. One study published in 2013 surveyed more than 630 women obtaining abortions and found that many are forced to divert money meant for living expenses—such as rent (14%), food (16%) or utilities and other bills (30%)—as they scrape together the funds to pay for the procedure.[15] These findings are hardly surprising when put together with other studies showing that many Americans do not have adequate savings to cover a financial emergency of any kind. According to a survey conducted by the National Foundation for Credit Counseling, 46% of Americans said that if they needed $1,000 for an unplanned expense, they would have to borrow it from friends or family; sell or pawn their personal items; or neglect paying rent, utilities or some other obligation.[16]

Because of the time and effort it takes to scrape together the funds, many poor women have to postpone their abortion. One study highlighted in the 2009 literature review compared the experiences of women who had abortions at a clinic in Missouri in 1977 (when Medicaid coverage for abortion was available) and in 1982 (when coverage was generally not available).[17] In 1977, Medicaid-eligible women seeking abortions experienced no delay in obtaining the procedure, compared with higher income women. In 1982, Medicaid-eligible women having an abortion did so about a week later than more affluent women; among those who said they had to postpone their procedure to raise the funds to pay for it, the delay was 2–3 weeks.

These substantial delays are problematic because both the cost and risk of an abortion increase as the pregnancy continues. In 2009, the median charge for an abortion was $470 at 10 weeks' gestation, but jumped to $1,500 at 20 weeks.[18] And the risk of complications from abortion—although exceedingly small at any point—increases exponentially with gestational age.[19] Thus, a poor woman seeking an abortion is often caught in a vicious cycle: The longer it takes for her to obtain the procedure, the harder it is for her to afford it—even as the risk to her health increases.

A Matter of Reproductive Justice

Starting in 2014, as a matter of perverse irony, more women than ever will be subject to the Hyde amendment, because the health care reform law includes a dramatic expansion of the overall Medicaid program that allows states to include all individuals with incomes under 133% of the federal poverty level ($25,974 for a family of three[20]). Moreover, as the health insurance marketplaces roll out this fall (selling coverage starting on January 1, 2014), it will quickly become clear how insurance plans are positioning themselves and to what extent the new norm regarding abortion coverage is veering toward exclusion, rather than inclusion.

By singling out abortion as something other than a legitimate medical procedure deserving of health insurance coverage, the government is further entrenching a two-tiered system of health care in which low-income women do not have the same freedom to make their own decisions as those who can afford abortion. As Justice Thurgood Marshall noted in his dissenting opinion in *Harris v. McRae*, the Hyde amendment was "designed to deprive poor and minority women of the constitutional right to choose abortion." It is a "form of discrimination repugnant to the equal protection of the laws guaranteed by the Constitution [that] marks a retreat from *Roe v. Wade* and represents a cruel blow to the most powerless members of our society."

Indeed, the Hyde amendment and its progeny have put obstacles in the path of women seeking abortion and hurt the very people that health insurance should benefit the most. The whole purpose of health insurance is to ensure that individuals can afford unexpected medical bills in the case of an unplanned event, and unintended pregnancy—or a much-wanted pregnancy that goes horribly wrong—is the very definition of an unplanned event.

Restrictions on insurance coverage of abortion fall hardest on poor women, who are already disadvantaged in a host of other ways, including in their access to the information and services necessary to prevent unplanned pregnancy in the first place. Compared with higher income women, poor women are five times as likely to have an unintended pregnancy, five times as likely to have an abortion and six times as likely to have an unplanned birth.[21,22] Moreover, abortion has become increasingly concentrated among poor women: In 2008, 42% of women obtaining abortions had incomes below 100% of the poverty level—a large increase from 27% in 2000.[23]

Pushing for incremental improvements to current abortion restrictions to ensure coverage at least in cases of life endangerment, rape and incest is an important goal for abortion rights advocates. Yet, the original, more ambitious agenda to completely repeal the discriminatory abortion policies that pervade federal and state laws remains. The goal is that the federal government, in its role as insurer and employer, should ensure that coverage for abortion services is included in the health insurance it provides to women and arranges for

its employees and their dependents. Moreover, there should be no government restrictions that prohibit or otherwise interfere with abortion coverage in private health insurance plans.

Lifting the existing bans would validate abortion as the legal, constitutionally protected and medically appropriate health care service that it is. Every woman should have affordable and comprehensive health care coverage that includes coverage for abortion care—regardless of the type of insurance she has, her income or her zip code. In the words of Jessica González-Rojas, executive director of the National Latina Institute for Reproductive Health, abortion coverage is fundamentally a matter of reproductive health, rights and justice: "Each of us, not just some of us, must be able to make the important decision of whether to end a pregnancy. For too long, politicians have been allowed to deny a woman's abortion coverage just because she is poor.... Together we are standing up to say 'enough.'"[24]

www.guttmacher.org

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References

1. Blake A, GOP congressman: Rate of pregnancies from rape is 'very low', *Washington Post*, June 12, 2013, <http://www.washingtonpost.com/blogs/post-politics/wp/2013/06/12/gop-congressman-rate-of-pregnancies-from-rape-is-very-low/>, accessed Aug. 20, 2013.

2. Blake A, Todd Akin, GOP Senate candidate: "Legitimate rape" rarely causes pregnancy, *Washington Post*, Aug. 19, 2012, <http://www.washingtonpost.com/blogs/the-fix/wp/2012/08/19/todd-akin-gop-senate-candidate-legitimate-rape-rarely-causes-pregnancy/>, accessed Aug. 20, 2013.

3. McDuffee A, Mourdock and rape as 'something God intended' and more, *Washington Post*, Oct. 24, 2012, <http://www.washingtonpost.com/blogs/thinktanked/wp/2012/10/24/mourdock-and-rape-as-something-god-intended-and-more-am-briefing/>, accessed Aug. 20, 2013.

4. Rosoff JI, Ban on Medicaid funds for abortion declared unconstitutional, ruling applies nationwide, *Planned Parenthood-World Population Washington Memo*, 1976, W-18:1–2.

5. Rosoff JI, Congress and the Hyde Amendment: "The normal democratic process?" *Planned Parenthood-World Population Washington Memo*, 1977, W-11:3–4.

6. Guttmacher Institute, State funding of abortion under Medicaid, *State Policies in Brief (as of August 1, 2013)*, 2013, <http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf>, accessed Aug. 20, 2013.

7. National Association of Insurance Commissioners, *NAIC Form Review White Paper*, June 27, 2012, <http://www.naic.org/documents/committees_b_related_wp_form_review.pdf>, accessed Aug. 20, 2013.

8. Guttmacher Institute, Restricting insurance coverage of abortion, *State Policies in Brief (as of August 1, 2013)*, 2013, <http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf>, accessed Aug. 20, 2013.

9. Henshaw SK et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, New York: Guttmacher Institute, 2009, <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf>, accessed Aug. 26, 2013.

10. Cook PJ et al., The effects of short-term variation in abortion funding on pregnancy outcomes, *Journal of Health Economics*, 1999, 18(2):241–257, <http://www.sciencedirect.com/science/article/pii/S0167629698000484>, accessed Aug. 26, 2013.

11. Perry S, A closer look at Bachmann's '30 percent increase in abortions' claim, *MinnPost*, Mar. 23, 2010, <http://www.minnpost.com/second-opinion/2010/03/closer-look-bachmanns-30-percent-increase-abortions-claim>, accessed Aug. 20, 2013.

12. Gold RB, Insurance coverage and abortion incidence: Information and misinformation, *Guttmacher Policy Review*, 2010;13(4):7–10, <http://www.guttmacher.org/pubs/gpr/13/4/gpr130407html>, accessed Aug. 20, 2013.

13. Whelan P, Abortion rates and universal health care, *New England Journal of Medicine*, 2010, 362:e45, <http://www.nejm.org/doi/full/10.1056/NEJMp1002985>, accessed Aug. 20, 2013.

14. Foster DG, Roberts SCM and Mauldon J, Socioeconomic consequences of abortion compared to unwanted birth, abstract presented at the annual meeting of the American Public Health Association, San Francisco, Oct. 27–31, 2012, <https://apha.confex.com/apha/140am/webprogram/Paper263858.html>, accessed Aug. 26, 2013.

15. Jones RK, Upadhyay UD and Weitz TA, At what cost?: Payment for abortion care by U.S. women, *Women's Health Issues*, 2013, 23(2):e173–e178, <http://www.guttmacher.org/pubs/journals/j.whi.2013.03.001.pdf>, accessed Aug. 20, 2013.

16. National Foundation for Credit Counseling, Majority of Americans do not have money available to meet an unplanned expense, news release, Aug. 15, 2011, <http://www.nfcc.org/NewsRoom/newsreleases/FLOI_July2011Results_FINAL.cfm>, accessed Aug. 20, 2013.

17. Henshaw SK and Wallisch LS, The Medicaid cutoff and abortion services for the poor, *Family Planning Perspectives*, 1984, 16(4):170–172 & 177–180.

18. Jones RK and Kooistra K, Abortion incidence and access to services in the United States, 2008, *Perspectives on Sexual and Reproductive Health*, 2011, 43(1):41–50, <http://onlinelibrary.wiley.com/doi/10.1363/4304111/pdf>, accessed Aug. 26, 2013.

19. Ferris LE et al., Factors associated with immediate abortion complications, *Canadian Medical Association Journal*, 1996, 154(11):1677–1685, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1487918/pdf/cmaj00095-0071.pdf>, accessed Sept. 6, 2013.

20. Department of Health and Human Services, Annual update of the HHS poverty guidelines, *Federal Register*, 2013, 78(16):5182–5183, <http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf>, accessed Aug. 20, 2013.

21. Jones RK and Kavanaugh ML, Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion, *Obstetrics & Gynecology*, 2011, 117(6):1358–1366, <http://journals.lww.com/greenjournal/Fulltext/2011/06000/Changes_in_Abortion_Rates_Between_2000_and_2008.14.aspx>, accessed Sept. 6, 2013.

22. Finer LB and Zolna MR, Unintended pregnancy in the United States: incidence and disparities, 2006, *Contraception*, 2011, 84(5):478–485, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/#!po=5.55556>, accessed Sept. 6, 2013.

23. Jones RK, Finer LB and Singh S, *Characteristics of U.S. Abortion Patients, 2008*, New York: Guttmacher Institute, 2010, <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>, accessed Aug. 26, 2013.

24. All* Above All, Women's health, rights and justice advocates unite to launch bold new campaign: All* Above All, news release, Washington, DC: All* Above All, July 23, 2013.

NARAL
Pro-Choice America Foundation

"No Taxpayer Funding for Abortion Act" (H.R.7):
An Extreme Attack on Women's Access to Abortion Coverage

Testimony submitted by

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President

Also on Behalf of

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U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution and Civil Justice

January 9, 2014

Members of the Judiciary Subcommittee on the Constitution: I am honored to submit this testimony on behalf of NARAL Pro-Choice America, our state affiliates, and the pro-choice Americans we represent.

Today you are considering the "No Taxpayer Funding for Abortion Act" (H.R.7), introduced by Rep. Chris Smith (R-NJ), a bill that is misleading in its claim that it ends public funding for abortion care. This bill is *not* about public funding. Current law is clear: sadly, federal funding of abortion care is forbidden, except in very narrow circumstances. Instead, this bill is an attempt to reopen the debate on private insurance coverage of abortion and to continue a long series of political attacks against the Affordable Care Act (ACA). Moreover, contrary to what the bill's proponents claim, it is a simple fact (one that a federal appeals court confirmed) that no federal dollars may be used to pay for abortion services under the ACA. "The express language of the [ACA] does *not* provide for tax-payer funded abortion," the court wrote. "That is a fact, and it is clear on its face."[1]

Instead, the Smith legislation opens an entirely new front in anti-abortion forces' unending campaign to ban the procedure. Beyond permanently blocking abortion coverage for low-income women, civil servants, and military women, this proposal would impose the core provision of the failed Stupak-Pitts abortion-coverage ban on the new health system; jeopardize the availability of private abortion coverage nationwide; levy tax penalties on any small business that provides comprehensive health coverage to its employees; and create a troubling new restriction on abortion that could spur the Internal Revenue Service to audit rape survivors.

Coming on the heels of a debate over health-care reform during which anti-choice lawmakers claimed they were "merely" trying to ban federal funding for abortion, this bill exposes that their view of "public funding" bears no resemblance to reality. In an unprecedented departure from current law, the Smith legislation seeks to define public funding as falsely including *private* money that the government has decided not to tax—a politically driven fiction that is not supported by existing law.[2] The Smith bill would extend unprecedented limitations on abortion access to a much larger share of the population than any current law and impose sweeping changes to tax policy.

Revives Core Provision of the Stupak-Pitts Amendment

In an effort to reopen the contentious issue of abortion coverage, the Smith legislation revives the core provision of the failed Stupak-Pitts amendment, and effectively would end abortion coverage for women in state insurance exchanges who use their own, private funds to pay for their insurance. The Smith bill makes it highly unlikely that insurance companies will opt to offer abortion coverage in state exchanges: it forbids any plan offering such coverage from accepting even one subsidized customer, forcing insurers to choose between offering their product without abortion coverage to the entire universe of consumers in a state exchange and

offering a benefits package that does include abortion services to a small minority of unsubsidized customers. (Because a vast majority of participants in state insurance exchanges will be subsidized,[3] it seems clear which choice insurers are likely to make.) As a result, in addition to women who will pay part, or even most, of their insurance premium with private funds, millions of unsubsidized individuals and small-businesses employees who obtain insurance through a state health-insurance exchange will be denied abortion coverage.

In addition to restricting who may purchase abortion coverage within state insurance exchanges, the Smith bill would impose crippling administrative burdens on plans that wish to cover abortion care. If the Smith bill becomes law, insurance companies that offer abortion coverage—absent political interference, research shows that 87 percent of plans do[4]—would face high costs, technical complexities, and onerous administrative requirements.[5]

Moreover, the bill's virtual ban on abortion coverage—together with its imposition of tax penalties on the purchase of plans that include abortion coverage—will affect not only state health-insurance exchanges, but can be expected to have a detrimental, industry-wide impact on abortion coverage in the entire private insurance market.[6] According to health-policy experts, as insurance exchanges grow they will have a greater effect on the health-insurance industry as a whole, eventually becoming the de facto standard for benefits packages.[7] Over time, the Smith bill's requirements could cause the elimination of coverage of abortion services for most women—not just those who purchase plans through a health-insurance exchange. In fact, during a congressional hearing on an earlier version of this bill, a witness testifying in support of the bill predicted this exact outcome, stating that "the new legislation, when combined with other existing laws, may provide a 'tipping point' where coverage without abortion becomes the usual norm for health insurance."[8]

Imposes Tax Penalties on the Purchase of Abortion Coverage

We understand that today's hearing and this subcommittee's jurisdiction does not extend to the tax-related provisions of this bill; nevertheless, we offer the following remarks about those sections so that members have a full picture of the bill's reach and scope.

The Smith legislation interferes with coverage of abortion services within the private-insurance market and makes chaotic changes to tax policy. The legislation would force millions of families to pay taxes that others do not have to pay on their health-insurance benefits if their plan includes abortion. It does so by imposing tax penalties on many individuals and small businesses that choose private health plans that cover abortion care. In levying higher taxes on plans that include abortion coverage, the Smith bill severely threatens the private market for comprehensive insurance coverage that includes abortion care. It seems obvious that the whole point of the scheme is to drive consumers away from these plans by increasing the cost of health-insurance.

Specifically, the bill would:

- Force small businesses to choose whether to accept the Small Business Health Tax Credit enacted as part of the health-care law or to offer their employees comprehensive insurance plans that will cover all their potential health needs, including abortion care. Under the Smith bill, insurance plans that include abortion benefits are ineligible for the tax credit. Four million small businesses are estimated to be eligible for the credit if they provide health care to their workers.[9]

- Take away tax benefits from self-employed persons if their health-insurance plans include abortion coverage. Currently, self-employed persons are able to deduct the cost of their insurance policy from their income taxes. The Smith bill, however, makes all plans that cover abortion non-deductible.[10]

- Impose tax penalties on many individuals who have high out-of-pocket health-care costs. Current law allows individuals to deduct all health-care expenses—including insurance premiums—that exceed 7.5 percent of their gross income. The Smith bill, however, would make insurance premiums for plans that include abortion coverage non-deductible.[11]

- Restrict the use of private dollars placed in tax-preferred Health Savings Accounts (HSAs). The Smith bill forbids individuals from using private funds saved in HSAs from being used to pay for abortion care, except in extremely limited circumstances.

- Potentially spur the Internal Revenue Service (IRS) to audit rape and incest survivors who require abortion services. Because, as described above, the bill eliminates medical-expense deductions for abortion care, with exceptions only for cases of rape, incest, or when a woman's life is in danger, tax experts confirm that the IRS would have to enforce this provision—and could audit any "questionable" benefit claims.[12] As a result, a woman could be forced to defend her abortion claim to *tax agents* if she were a survivor of rape or incest.

The National Women's Law Center (NWLC) quantified the impact the tax penalties an earlier version of this legislation would have imposed on hypothetical individuals and small businesses. According to the NWLC's analysis:

- A restaurant with 40 half-time employees whose wages totaled $500,000 and health-care costs totaling $240,000 per year would be eligible for a Small Business Health Tax Credit under current law. Under the Smith bill, however, that restaurant's taxes would be *raised* by $28,000 if its health insurance plan includes abortion coverage.[13]

- The Smith bill would cost a married self-employed individual who had a combined income of $98,000 and $7,000 in annual insurance premiums an *additional* $1,750 per year if that individual's insurance plan covered abortion services.[14]

- A woman who makes $25,000 is eligible to deduct from her taxable income any amount over $1,875 spent on health-care expenses, including on insurance premiums. If her insurance plan covered abortion, however, the Smith bill would take away her $1,731 deduction.[15]

Recodifies Existing Bans on Abortion Coverage

This legislation also would reinforce long-standing discriminatory bans on publicly funded abortion care by permanently denying low-income women, federal employees, women in the military, and residents of the District of Columbia access to abortion coverage.

Again, current law already bans public funding for abortion care. Currently, most of these bans are renewed annually in appropriations bills. The Smith bill writes the bans into permanent law. This would result in permanently denying abortion coverage to the nearly 20 million individuals insured by Medicaid,[16] the 7.6 million non-elderly and disabled individuals currently enrolled in Medicare,[17] and the 2.1 million American Indians and Alaska Natives who receive health insurance through the Indian Health Service (IHS).[18]

Additionally, the U.S. government offers health benefits plans to nearly eight million federal employees, their dependents, and retirees, 44 percent of which are women.[19] The Smith bill permanently bans abortion coverage for these federal employees and their dependents, even though these workers pay a portion of their health insurance premiums with their own private dollars.

Similarly, the bill also recodifies the ban on abortion care for women in military hospitals overseas, and permanently denies abortion coverage to the 9.6 million individuals who receive health insurance through TRICARE, the military health plan.[20]

Likewise, the Smith bill would permanently deny abortion coverage to Peace Corps volunteers. Of the 7,209 U.S. citizens who are currently volunteers and trainees for the Peace Corps, 63 percent are women.[21] Finally, the Smith bill also reimposes the ban on Washington, D.C.'s ability to use its own local funds to cover abortion services for the 78,200 low-income women currently enrolled in its Medicaid program—an unfair restriction that Congress lifted in 2009.[22]

Overall, the more than 15 million adult women who receive health coverage through all the government-sponsored programs described above permanently would lose access to abortion coverage, except in incredibly narrow circumstances.[23]

Congress should be *repealing* these abortion bans, not recodifying them. Discriminatory bans on abortion coverage create significant, often insurmountable, obstacles for women seeking abortion care. Low-income women often have difficulty raising the money to pay for abortion services and research indicates that economic barriers often cause them to obtain abortion care two to three weeks later in pregnancy than do wealthier women.[24] This is especially problematic because the cost of abortion care increases the longer the pregnancy continues. Later abortion care, which is already inaccessible to women in many states, ranges into the thousands of dollars, and can pose an insurmountable cost.[25] These burdens also disproportionately affect women of color, who, because of the connection between racial discrimination and economic disadvantages, are more likely than white women to be poor, to lack health insurance, and to rely on government health-care programs or plans.[26] Reiterating the abortion-coverage bans in permanent law adds insult to already deeply injurious policies. Moreover, these discriminatory bans require no bolstering: a CBO report on a previous version of the bill's fiscal impact states that gains for the federal government would be negligible[27]—confirming yet again that no prohibited dollars are used to fund abortion services beyond the narrow exceptions allowed by law.

Finally, the Smith bill also recodifies the Helms amendment, a policy that denies some of the world's poorest women access to safe abortion care by prohibiting the use of U.S. funds to pay for abortion services in developing countries. Not only would the Smith bill jeopardize the availability of abortion coverage for American women, it would have detrimental international ramifications as well.

Inadequate Exceptions

It should also be noted that the Smith bill's ban on abortion coverage in the new health system lacks any kind of exception that would protect the health of the woman, or provide care in cases of fetal anomaly. While the absence of insurance coverage for abortion care hurts all women, it particularly harms those for whom pregnancy threatens their health. Many women welcome pregnancy at some point in their lives and can look forward to a safe childbirth; however, for some, pregnancy can be dangerous, and abortion restrictions, such as the Smith bill, that make no exceptions to protect women's health endanger these women. The Smith legislation would limit access even for women in the most desperate of circumstances, whose care is often the most expensive and the most urgent. For example:

- Vikki Stella, a diabetic, discovered months into her pregnancy that the fetus she was carrying suffered from several major anomalies and had no chance of survival. Because of Vikki's diabetes, her doctor determined that induced labor and Caesarian section were both riskier procedures for Vikki than an abortion. The procedure not only protected Vikki from immediate medical risks, but also ensured that she would be able to have children in the future. [28]

- Jennifer Peterson was 35 and pregnant when she discovered a lump in her breast. Tests showed she had invasive breast cancer. The cancer and its treatment, separate and

apart from the pregnancy, were a threat to her health. Her pregnancy posed a significant added threat to her health during the onset and treatment of her cancer. About one in 3,000 pregnant women also has breast cancer during her pregnancy, and for these women, a health exception is absolutely necessary.[29]

- Gilda Restelli was well into her pregnancy when doctors discovered that her fetus had only fragments of a skull and almost no brain. She and her husband had been told by medical experts that their baby had almost no chance of survival after birth. Restelli quit her job, not because she was physically incapacitated, but because she could no longer bear the hearty congratulations of strangers who were unaware of the tragic circumstances surrounding her pregnancy. The Restellis made the agonizing decision to end the pregnancy.[30]

- D.J., a federal employee, was 11 weeks into a wanted pregnancy when she learned that her fetus had anencephaly, meaning that the fetus would never develop a brain. Her doctor provided abortion care at a local hospital. Several months later, she received a bill for $9,000 – and was told her insurance would not cover the costs because, as a federal employee, she was not entitled to insurance coverage for abortion services unless the pregnancy endangered her life.

Earlier Version of H.R.7 Redefined Rape and Incest

As a final note, it is worth reminding members that until sponsors were forced to remove it after public outcry, the original version of H.R.7 had an additional extreme and mean-spirited provision that would have narrowed the already severely limited rape and incest exceptions that exist in federal law. Most federal laws that restrict access to abortion services allow exceptions for instances of life, rape, or incest. The Smith bill's original language, however, limited these exceptions to include only victims of "forcible rape" and "incest with a minor." This restriction would have applied to all federal programs, affecting not only low-income women in Medicaid, but women in the military and all federal employees, as well. It also would have applied to state health-insurance exchanges, and to the tax-benefits restrictions applied to the private insurance market. While ultimately the bill's sponsors dropped this offensive provision, its inclusion in the original version offers another indication of the bill's extreme nature.

Conclusion

The Smith bill represents an extreme new anti-choice agenda that drastically alters the concept of "public funding." In trying to redefine this term falsely, this proposal not only does further injustice to low-income women, but also jeopardizes the ability of private citizens to use their own dollars to purchase abortion coverage in the new health system and levies harsh penalties on small businesses that choose comprehensive insurance coverage. Reasonable lawmakers,

even those who may not agree with the pro-choice perspective on the issue of public funding for abortion, should recognize this bill for what it is: a radical departure from the already-unacceptable status quo.

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[1] *Susan B. Anthony List v. Driehaus*, 805 F. Supp. 2d 423, 431 (S.D. Ohio 2011).

[2] H.R. REP. NO. 112-38, at 44, 45 (2011). *See also Walz v. Tax Comm'n of City of New York*, 397 U.S. 664, 675 (1970).

[3] Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Rep. John Dingell (Nov. 6, 2009), *available at* http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf.

[4] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSP. ON SEXUAL & REPROD. HEALTH 2, 72–79 (2004), *available at* http://www.guttmacher.org/pubs/journals/3607204.html (last visited Aug. 1, 2013).

[5] Sara Rosenbaum et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* 25 (2009), *available at* http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000000311/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Jan. 2, 2014).

[6] Sara Rosenbaum et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* 9 (2009), *available at* http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000000311/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Jan. 2, 2014).

[7] Sara Rosenbaum et al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* 9 (2009), *available at* http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000000311/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Jan. 2, 2014).

[8] *No Taxpayer Funding for Abortion Act: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 112th Cong. (2011) (oral testimony of Richard M. Doerflinger, associate director, Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops (USCCB)). While the testimony pertained to an earlier version of this bill (H.R.3), H.R.7 includes identical tax-related provisions in its current form.

[9] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[10] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[11] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[12] *Hearing on the Tax Related Provisions of H.R.3: Hearing Before the Subcomm. on Select Revenue Measures of the H. Comm. on Ways and Means*, 112th Cong. (2011) (oral testimony of Thomas A. Barthold, chief of staff, the Joint Comm. on Taxation). While the expert findings pertained to an earlier version of this bill (H.R.3), H.R.7 includes identical tax-related provisions in its current form.

[13] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[14] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[15] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[16] Kaiser Family Foundation, "Distribution of the Nonelderly with Medicaid by Age," *State Health Facts* (2012) *available at* http://kff.org/medicaid/state-indicator/distribution-by-age-4/ (last visited Jan. 2, 2014).

[17] Kaiser Family Foundation, "Distribution of Medicare Beneficiaries by Eligibility Category," *State Health Facts* (2009) *available at* http://kff.org/medicare/state-indicator/beneficiaries-by-eligibility-category/ (last visited Jan. 2, 2014).

[18] Indian Health Service (IHS), *Indian Health Service: A Quick Look* (Jan. 2013), *available at* http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/QuickLook_2013.pdf (last visited Jan. 2, 2014).

[19] U.S. Office of Personnel Management, *The Fact Book, Federal Civilian Workforce Statistics* (2007) 54, 82, *at* http://www.opm.gov/feddata/factbook/ (last visited Jan. 2, 2014).

[20] TRICARE, *Number of Beneficiaries*, *at* http://www.tricare.mil/Welcome/About/Facts/BeneNumbers.aspx (last visited Jan. 2, 2014).

[21] Peace Corps, *Fast Facts* (last modified Nov. 20, 2013), *at* http://www.peacecorps.gov/about/fastfacts/ (last visited Jan. 2, 2014).

[22] Consolidated Appropriations Act of 2010, P.L. 111-117, 111th Cong. (2009).

[23] Kaiser Family Foundation, "Health Insurance Coverage of Women 19-64," *State Health Facts* (2012) *at* http://www.statehealthfacts.org/comparebar.jsp?typ=1&ind=652&cat=3&sub=178 (last visited Jan. 2, 2014).

[24] Center for Reproductive Rights, *Women's Reproductive Rights in the United States: A Shadow Report* (2006).

[25] Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 14 (2008), *available at* https://www.guttmacher.org/pubs/journals/4000608.pdf (last visited Jan. 2, 2014).

[26] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *The Reproductive Rights and Health of Women of Color* (2000).

[27] Cong. Budget Office Cost Estimate, H.R.3: No Taxpayer Funding for Abortion Act (Mar. 15, 2011), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12105/hr3.doc.pdf (last visited Jan. 2, 2014). While the report's findings pertained to an earlier version of this bill (H.R.3), H.R.7 includes identical tax-related provisions in its current form.

[28] *Partial Birth Abortion Ban of 1995: Hearing on H.R.1833/S.939 Before the Senate Comm. on the Judiciary*, 104th Cong. (1995) (testimony of Vikki Stella).

[29] The National Cancer Institute, *General Information about Breast Cancer and Pregnancy* (Sept. 19, 2013), *available at* http://www.cancer.gov/cancertopics/pdq/treatment/breast-cancer-and-pregnancy/patient (last visited Jan. 2, 2014).

[30] William Raspberry, *Abortion: A Tough Case*, WASH. POST, Aug. 31, 1998, at A21; Felice J. Freyer, *Hospital Agrees to End Tragic Pregnancy*, PITTSBURGH POST-GAZETTE, Aug. 30, 1998, at A3.

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Statement of National Council of Jewish Women on HR 7, No Taxpayer Funding for Abortion Act

Written Testimony submitted by
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Subcommittee on the Constitution and Civil Justice

January 9, 2014

The National Council of Jewish Women (NCJW) is a grassroots organization of volunteers and advocates who are inspired by Jewish values. Since 1893, NCJW members have turned progressive ideals into action, striving for social justice by improving the quality of life for women, children, and families, and by safeguarding individual rights and freedoms.

NCJW has a long history of strong support for the protection of every female's right to reproductive choices, including safe and legal abortion, access to contraception, and the elimination of obstacles that limit reproductive freedom. The ninety-thousand members, volunteers, and supporters of NCJW have long supported abortion care as an essential component in the spectrum of comprehensive, confidential, affordable reproductive health services that must be accessible to women, regardless of age or ability to pay. We believe that each woman must have the right to exercise her own moral judgment when making personal decisions, including those that affect her reproductive life. Ensuring that women, regardless of financial status, age, or other factors have access to comprehensive reproductive health services is essential not only to a woman's health but also to her full equality and economic opportunity.

We view HR 7, the "No Taxpayer Funding for Abortion Act," introduced by Representative Chris Smith (R NJ), as harmful to women and families on several fronts. This legislation would unjustly target their pocketbooks, imposing financial barriers on many American workers and discriminating against low-income women; cruelly endanger their health; and wrongly erode their right to privacy and religious liberty.

If enacted, the government would greatly restrict consumer options in the private insurance market and penalize the insurance companies and employers who offer abortion-inclusive health insurance coverage. While more than 80 percent[1] of private

[1] Guttmacher Institute, *Memo on Private Insurance Coverage of Abortion*, http://www.guttmacher.org/media/inthenews/2011/01/19/index.html (Feb. 3, 2011)

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plans today offer such coverage, HR 7 would increase taxes on the individuals and families who now have abortion coverage and want to keep it, while barring others from buying this coverage with their own money. Penalizing consumers – male and female – with increased taxes as a means of restricting abortion coverage is an unjust and extreme move that would harm women, men, and their families.

HR 7 also puts women at risk. It would make permanent the harmful policy known as the Hyde Amendment, withholding coverage of abortion for women who access health coverage or care through federal health programs. Doing so would codify discrimination against women based on their income or source of insurance, eroding the rights of women enrolled in Medicaid, US servicewomen, federal employees, Native American women, and others. It further imposes this unjust policy on women living in the District of Columbia, despite the interests of local taxpayers and elected officials.

NCJW strongly opposes this aspect of HR 7 in particular, as it would disproportionately harm the health, financial security, and well-being of women who already face economic and other barriers in accessing health care, including safe abortion. When a woman needs to end a pregnancy, it is critical that she have access to safe medical care. Insurance coverage of abortion care, whether through a private or public plan or program, ensures she will be able to see a licensed, quality health provider. Withholding coverage, as this bill would permanently do, can impose great financial burdens on women and families with limited resources. The impact of those obstacles can be far-reaching: a woman may be forced to delay needed care, unnecessarily increasing the risk of an otherwise safe procedure, or shut off her phone or utilities just to pay for the care she needs. Indeed, recent studies show that a woman who seeks abortion services but is denied is three times more likely to fall into poverty than a woman who can access this care[2].

In addition, while this bill does include a narrow exception for care in cases of rape, incest, and when a woman's life is at risk, the legislation changes tax rules to disqualify medical deductions of abortion related expenses. The application of this provision might trigger an Internal Revenue Service investigation into survivors of sexual violence and assault who seek abortion, potentially adding to the trauma and hardship surrounding such an experience.

NCJW believes that the above reasons alone should be enough to oppose HR 7, but this legislation does take an additional step that makes it especially offensive to NCJW and all Americans who value individual rights and freedoms. The so-called "No Taxpayer Funding for Abortion Act" would erode our nation's guarantee of religious liberty.

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[2] Joshua Lang, "What Happens to Women Who are Denied Abortions?" *New York Times*, June 12, 2013 (http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=all&_r=1&)

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We recognize that abortion is a complex issue – replete with moral, bio-ethical, philosophical and theological implications. What is clear is that the issue engenders strong feelings on all sides. Different religions have differing views on when life begins; and even within religions, there can be varying opinions. We submit that this diversity of opinions is a question that our nation has answered by upholding the key, founding principle of religious freedom. A central part of the United States Supreme Court's 1973 decision in *Roe v. Wade* recognized that different moral and religious traditions have differing views of abortion.

Reproductive rights are integrally bound up with religious freedom. As a faith-based women's organization, we understand that those who would restrict women's access to abortion and other reproductive health care services are often motivated by their religious belief -- seeking to impose their religious views on others. Even if one doesn't personally agree with abortion, for whatever reason, it is unjust to restrict a women's exercise of her constitutional rights and freedoms based on her income, source of insurance, or other factors. In this context, religious liberty means that women are valued as moral decision-makers. A woman must be free to make personal, complex decisions about her health and reproductive life based on her own religious beliefs, moral views, and conscience, in consultation with her health provider, family, religious leader – or whomever she chooses to involve. For the legislature to mandate one religion's views on this very personal issue is to restrict religious liberty for all.

Judaism teaches that, during a pregnancy, the life of the mother takes precedence over the potential life of a fetus. In fact, the Jewish scholar, Rabbi Sofer, taught: "no woman is required to build the world by destroying herself."[3] We respect and recognize the right of religious groups whose beliefs differ from ours to follow the dictates of their faiths in this matter. But we ask no less for ourselves.

We oppose HR 7 because it blatantly disregards and undermines the basic right of our *freedom* to choose. And both *religious* freedom and *personal* freedom are the underpinnings of this right.

NCJW strongly and respectfully urges you to oppose HR 7. This legislation would take extreme measures that would not only impose discriminatory financial hardships on women and families and endanger women's health, but it would erode their religious freedom. As you deliberate the suitability and constitutionality of this legislation, we hope that you will take into account not only its detrimental impact on women's overall health, equality, and economic opportunity, but also its impact on religious liberty.

[3] Resp. Hatam Sofer, E.H. No. 20

NHeLP
NATIONAL HEALTH LAW PROGRAM

January 8, 2014

The Honorable Trent Franks
Chairman
Subcommittee on the Constitution
and Civil Justice
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515

The Honorable Jerrold Nadler
Ranking Member
Subcommittee on the Constitution
and Civil Justice
Committee on the Judiciary
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515

RE: January 9, 2014 Hearing on "The No Taxpayer Funding for Abortion Act" (H.R. 7)

Dear Chairman Franks, Ranking Member Nadler, and Members of the House Judiciary Committee's Subcommittee on the Constitution and Civil Justice:

The National Health Law Program (NHeLP) strongly opposes H.R. 7, "The No Taxpayer Funding for Abortion Act," which would impose dangerous and unprecedented restrictions on women's access to abortion services, and, for the most vulnerable women, may put their lives at risk. H.R. 7 would permanently ban abortion coverage with only extremely narrow exceptions for low-income women who access their health care in publicly funded programs, and would make insurance coverage for an abortion almost impossible to obtain for any woman. The National Health Law Program is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. H.R. 7 is harmful to all women, but this testimony focuses on the public funding restrictions that disproportionately affect the low-income and women of color NHeLP serves.

H.R. 7 would make permanent the harmful Hyde Amendment, which discriminates against and disadvantages women who may most be in need of abortion services. It robs low-income women of the ability to make life decisions in the best interest of themselves and their families. A woman who is denied abortion services is more likely to have income below the federal poverty level and to receive public assistance than a woman who can get

the service.[1] The ban on abortion coverage in all but the very narrow circumstances of rape, incest, and life endangerment put the most vulnerable women at risk, jeopardizing their health and the financial security of their families.

Low income women, particularly low income women of color, already experience severe health disparities in reproductive health, maternal health outcomes, and birth outcomes. More than half of all women will have an unintended pregnancy and low-income women are more than twice as likely as the national average to have an unintended pregnancy. Unintended pregnancies present a public health concern as they are associated with problematic maternal and birth outcomes.[2] African-American and Latino women have the highest unintended pregnancy rates, and relatedly, the worst maternal and birth outcomes. For example, African-American women are three times more likely than their white counterparts to die from pregnancy-related complications.[3] H.R. 7 would exacerbate those disparities by denying women access to abortion services that may be necessary to protect their health and their lives.

Every person expects that the care they receive from their health care provider will meet established standards of care. Clinical guidelines and generally agreed upon medical practices are baseline practices that are accepted in the profession and codified in professional policies and position statements. Accordingly, several leading health professional and medical societies in the United States and Western Europe have issued accepted standards of care for reproductive health, which include providing medically accurate contraceptive information, services, and supplies, as well as abortion care. This is particularly important for women with emergent health issues and those whose management of chronic health conditions requires preconception and interconception care, which is care provided to a woman before and between pregnancies.[4] Specifically, accepted standards of medical care advise that women suffering chronic conditions – such as pregestational diabetes, lupus, and cardiovascular disease that could lead to adverse health and birth outcomes should avoid pregnancy until their conditions are under control.[5] H.R. 7's denial of funding for low-income women with these complications could mean that a woman cannot afford to receive health care that meets the

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[1] Diana Greene Foster, Bixby Center for Global Reproductive Health, Department of Ob/Gyn, University of California, Address Socioeconomic consequences of abortion compared to unwanted birth, at Am. Public Health Assoc. Meeting (October 30, 2012), *available at* https://apha.confex.com/apha/140am/webprogram/Paper263958.html.

[2] Guttmacher Institute, *Unintended Pregnancy in United States* (Dec. 2013); National Health Law Program, *How the Threats to Medicaid Impact Reproductive Health Disparities* 1 (April 2011).

[3] Ctr. for Disease Control and Prevention, Reproductive Health: Pregnancy Mortality Surveillance System, http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html.

[4] For example, the American College of Obstetricians and Gynecologists, The American Medical Association, The Royal College of Obstetricians and Gynaecologists of the United Kingdom, The World Health Organization, The U.S. Preventive Services Task Force, and HHS' Centers for Disease Control and Prevention.

[5] National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women*, Standard of Care Project, 2010 (*citing* Johnson K., Posner SF, Biermann J, et al. Recommendations to Improve Preconception Health and Health Care – United States. A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care, MMWR Morbidity and Mortality Weekly Report Recommendations and Reports, 2006, 55: 1-23).

appropriate standards of care, and effectively interferes with a woman and her doctor's recommendation.

Similarly, a number of emergent medical conditions may put her or her fetus at serious risk even when a woman has decided to carry her pregnancy to term. As a result, access to safe and timely abortion services becomes critical. These conditions include but are not limited to: premature rupture of membranes, preeclampsia and eclampsia, anencephaly (fetus incompatible with life), and chronic conditions for which pregnancy termination may be medically appropriate. In these situations, accepted medical standards and guidelines from the American College of Obstetricians and Gynecologists, Royal College of Obstetricians and Gynaecologists of the United Kingdom, and the Cochrane Collaboration acknowledge that the patient must then decide to balance her health and life with the prospects of fetal survival. These standards and guidelines all recognize that a woman must make this decision. H.R. 7 deprives low-income women of the ability to make important personal life decisions about their families. Moreover, it puts at risk the health and lives of women with particular medical conditions for which pregnancy is counter-indicated.

Accordingly, we encourage the Subcommittee on the Constitution and Civil Justice, and your colleagues in the House of Representatives to protect the health of women and their right to quality and comprehensive reproductive health information and services.

Respectfully,

Emily Spitzer
Executive Director

House Judiciary Subcommittee on the Constitution and Civil Justice
H.R. 7, "No Taxpayer Funding for Abortion Act" Hearing Testimony

January 8, 2014

Dear Members of the House Judiciary Subcommittee on the Constitution and Civil Justice:

We write today to express our opposition to H.R. 7, the "No Taxpayer Funding for Abortion Act," and our deep concerns about the drastic harms it would cause. H.R. 7 is a sweeping ban on abortion coverage and another mean-spirited attempt to interfere with a woman's personal decision-making. The measure would fall hardest on women who are struggling to get by, who are disproportionately women of color, including Asian American and Pacific Islander (AAPI) women.

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue AAPI women's organization in the country. Our mission is to build a movement to advance social justice and human rights for AAPI women and girls. Since 1996, we have represented AAPI women, who are overwhelmingly pro-choice,[1] in pushing back against abortion bans that disproportionately impact women of color.

I. Harmful Impacts of Restrictive Abortion Bans

H.R. 7 is an extreme abortion ban that permanently blocks abortion coverage in public insurance, the District of Columbia, and the military. It also includes a ban on private market insurance in the new healthcare exchanges. These restrictions create a real impact on women and their families by limiting their ability to access abortion care when they need it. All health insurance plans, whether paid for by individuals, employers, or with government funds, should provide coverage for a full range of pregnancy- related medical care, including abortion care.

Our current laws impose unfair limitations on insurance coverage of abortion, and the No Taxpayer Funding for Abortion Act would make existing legislation like the Hyde Amendment permanent. The Hyde Amendment is extremely harmful for low income women and women of color who depend on programs like Medicaid for their health insurance. These restrictions makes abortion care unaffordable and out of reach for many of

[1] Nearly 70% of APA women support a woman's decision to have an abortion. Another 20% stated that they would support a woman's decision to have an abortion in certain cases such as rape or incest. National Asian Women's Health Organization, Expanding Options: A Reproductive and Sexual Health Survey of Asian American Women (Jan. 1997).

these women. Women struggling to make ends meet should not have limited access to health care services simply because of their income.

Policies that restrict insurance coverage of abortion, like the Hyde Amendment, are a very real concern for women in AAPI community. 1 in 10 Asian Americans, 1 in 7 Native Hawaiian and Pacific Islanders, and 1 in 5 Southeast Asians rely on Medicaid.[2] Additionally, 27% of Hmong and 21% of Bangladeshis live below the poverty line. [3] For communities struggling to make ends meet, it can be impossible to pay for abortion services out of pocket. Without the ability to access it, the right to abortion becomes meaningless. A woman should have access to abortion care regardless or her income or type of insurance.

II. Healthcare Barriers and Health Disparities of AAPI women

Many AAPI women face significant barriers to healthcare and have substantial health disparities. This measure would make healthcare outcomes for AAPI women even worse than they already are.

Many AAPI women are concentrated in low-wage employment that does not provide employer-based health insurance, and a high percentage of AAPI women are self-employed. Financial barriers also prevent many low-income women from purchasing private health insurance. Rates of public insurance in 2010 showed that 19% of all Asian groups enrolled in public insurance, with particularly high rates among the following: 28% of Native Hawaiians and Pacific Islanders, 37% of Bangladeshis, and 43% of Hmong.[4] Un-insurance rates of AAPIs exceed 18.1% compared with 16.3% of all Americans. The rate is even higher for Korean Americans at 25.5%.[5]

AAPI women have some of the highest rates of cervical cancer, and studies show that 24.1% of AAPI women have not had a pap test in the last three years.[6] Additionally, coronary disease is a leading cause of death among AAPI women, responsible for more than a quarter of all deaths.[7] AAPI women do not need another barrier to health care, and making abortion harder to obtain will exacerbate health outcomes for us.

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[2] ASIAN PACIFIC ISLANDER AMERICAN HEALTH FORUM, The Impact of Health Care Reform on Health Coverage for Asian Americans, Native Hawaiians, and Pacific Islanders (Dec. 2011), *available at* http://www.apiahf.org/sites/default/files/ PA-Factsheet12-2011.pdf

[3] National Coalition for Asian Pacific American Community Development, Spotlight: Asian American & Pacific Islander Poverty, at 11 (2013), *available at* http://nationalcapacd.org/sites/default/files/u12/aapi_poverty_report-web_compressed.pdf.

[4] Rose Chu et al., Assistant Secretary for Planning & Evaluation, HHS, The Affordable Care Act and Asian Americans and Pacific Islanders, at 2 (2012), *available at* http://aspe.hhs.gov/health/reports/2012/ACA&AsianAmericans&PacificIslanders/rb.pdf

[5] *Id.*

[6] The Henry J. Kaiser Family Foundation, Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level, Table 2.7 (June 10, 2009), *available at* http://www.kff.org/minorityhealth/upload/7886.pdf.

[7] Facts, Women of Color United for Health Reform, http://www.womenofcolorunited.net/learn-more-facts/ (last visited Jan. 17, 2013).

III. Women's Personal Decision-making and Well-being

A woman's health insurance should enable her to take care of her health and well-being. Providing insurance coverage for abortion care ensures a woman will be able to see a licensed, quality health provider and receive safe care. Withholding insurance coverage for abortion care can endanger a woman's health due to serious medical conditions that can be related to pregnancy. When people can plan if and when to have children, it is beneficial for them and for society as a whole.

The decision about whether to choose adoption, end a pregnancy, or raise a child must be left to a woman, with the counsel of her family, her faith, and her health care provider. And yet, because of the Hyde amendment, the poorest women in this country are often unable to make this decision without government interference.

IV. Conclusion

Politicians should not interfere with a woman's ability to make her own personal health care decisions. We do not always know a woman's circumstances. When public insurance covers pregnancy care but denies coverage for abortion, we're taking away a woman's ability to make important personal decisions based on what she knows is best for her and her family. Unjust obstacles are created for millions of women struggling to get by because of bans on public funding for abortion. These bans severely restrict their ability to make the best health care decisions for themselves and their families.

We ask the committee to oppose the "No Taxpayer Funding for Abortion Act" and all restrictions that place restrictions on women's health.

"No Taxpayer Funding for Abortion Act" (HR 7)

Testimony submitted by

Debra Ness, President
Andrea Friedman, Director of Reproductive Health Programs

U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution and Civil Justice

January 9, 2014

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The National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)(3) organization located in Washington, D.C. We have worked tirelessly for over forty years to expand access to quality, affordable health care for all Americans that includes comprehensive reproductive health services; to eliminate discrimination in the workplace; and to enable women to meet the dual demands of work and family. The National Partnership vehemently opposes H.R. 7, the deceptively titled "No Taxpayer Funding for Abortion Act," and we urge Congress to reject this legislation.

This radical proposal represents an extreme attack on abortion access. It would permanently codify the unjust and harmful restrictions on federal funding of abortion care that have long burdened low-income women and women who rely on the federal government for their health insurance, including those serving in the military and the Peace Corps, federal employees, and women served by the Indian Health Service. H.R. 7 would also prevent women with private insurance from using their health savings accounts and flexible spending accounts to pay for abortion care, increase taxes on small businesses that want to keep the health plans they already have that include abortion coverage, and prevent women purchasing private insurance through the health insurance marketplace from choosing a plan that includes abortion coverage if they are eligible for premium assistance. This unprecedented restriction on insurance coverage of abortion further harms women who already have their abortion coverage restricted and ultimately threatens the availability of abortion coverage in the entire private insurance market.

H.R. 7 Would Raise Taxes on Individuals and Small Businesses and Subject Women to "Rape Audits"

H.R. 7 would eliminate tax benefits for many small and individual private health plans solely because those plans include coverage of abortion care. For example, H.R. 7 would prohibit the use of health savings accounts and flexible spending accounts from being used for abortion care unless the pregnancy resulted from rape or incest or endangers a woman's life. These restrictions would effectively raise taxes on individuals by prohibiting them from using pre-tax dollars to pay for abortion care, penalizing the women and families who need this care in a way unprecedented for other legal medical care. Additionally, if a woman deducts the cost of an abortion that falls within one of the exceptions under H.R. 7, she could be audited for proof that the exception applies – an IRS agent could demand proof from a sexual assault survivor that her pregnancy was the result of rape.

Today, a majority of private health plans offer coverage that includes abortion care. H.R. 7 would eliminate tax benefits for private plans if those plans include abortion coverage, which means many small businesses that want to continue to offer comprehensive health coverage would not be able to take advantage of the Small Business Health Tax Credit, enacted as part of the Affordable Care Act (ACA). This tax credit for small businesses will be worth up to 50 percent of premium costs in 2014. Eliminating tax credits for small businesses that provide abortion coverage to their workers would force businesses to choose between facing significant tax increases and dropping their current insurance plans.

H.R. 7 Would Impose Unnecessary Restrictions on Private Plans in the Health Insurance Marketplaces and Threaten the Availability of Abortion Coverage

H.R. 7 bans any federal expenditure to private health plans that include abortion coverage. This means that low and moderate income individuals and families eligible for premium assistance to purchase health plans through the health insurance marketplaces would be unable to select private plans that include abortion care. Because the majority of consumers purchasing plans in the new marketplaces will be eligible for premium assistance, health plans would be faced with a reduced consumer pool and the administrative burdens of offering multiple plans, and would likely drop all abortion coverage in plans sold through the marketplaces. This would make insurance coverage of abortion unavailable even for consumers not taking advantage of premium assistance.

Moreover, the ACA already includes a provision that requires insurers choosing to offer plans that include abortion coverage to adhere to stringent accounting procedures to segregate federal funds from private dollars used to cover abortion care. While the National Partnership strongly opposes this provision in ACA, there is widespread agreement that the ACA already ensures that no federal funds can be used to pay for abortion coverage. To claim that further restrictions are needed is untrue and is only a ploy to promote an extreme attack on access to abortion care.

Since more Americans and small businesses are expected to purchase insurance through the marketplaces each year, over time, the size of employers eligible to participate is expected to grow as well. Because of the widespread impact, this bill would create an incentive for insurers to standardize insurance products and quickly eliminate coverage of abortion even outside the marketplaces. This marks an unprecedented restriction on the use of private funds and impedes the ability of women to choose health plans that cover their health care needs.

H.R. 7 Makes Existing Federal Restrictions on Abortion Coverage Permanent

H.R. 7 would codify existing restrictions on federal funding for abortion that prohibit abortion coverage in health insurance provided by the government, with few exceptions. These restrictions impact women covered through Medicaid, women serving in the military and dependents of military personnel, women receiving veteran's benefits, women serving in the Peace Corps, women covered through the Indian Health Service, federal employees, and women in federal correctional facilities. The bill would also make permanent a ban on the District of Columbia from using its own funds to pay for abortion care.

The National Partnership remains adamantly opposed to abortion funding bans because they threaten women's health by making it harder to obtain abortion care. They are especially burdensome for low-income women who do not have the funds to pay for care that is not covered by their health insurance. These women may go without enough food, utilities, and other necessities in order to gather enough money for their abortion, and they are often forced to seek abortion care later in pregnancy when the cost of the procedure is higher and poses a greater risk to a woman's health.

Conclusion

The National Partnership for Women & Families urges Congress to reject H.R. 7, the "No Taxpayer Funding for Abortion Act." The bill goes well beyond codifying the unjust restrictions on access to abortion care that have long burdened low-income women by taking away health coverage women already have and threatening to end all insurance coverage for abortion.

House Judiciary Subcommittee on the Constitution and Civil Justice Hearing Testimony
Congressional Hearing on H.R. 7, the "No Taxpayer Funding for Abortion Act"
January 9, 2013

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments regarding Congressman Chris Smith's ' H.R. 7, the "No Taxpayer Funding for Abortion Act", which is being considered in a hearing today before the U. S. House Judiciary Subcommittee on the Constitution and Civil Justice.

Planned Parenthood is the nation's leading provider and advocate of high-quality, affordable health care for women, men, and young people, as well as the nation's largest provider of sex education. With more than 750 health centers across the country, Planned Parenthood health centers provide affordable birth control, lifesaving cancer screenings, testing and treatments for STDs and other essential care to nearly three million patients every year. Nearly 80% of Planned Parenthood patients have incomes at or below 150 percent of the federal poverty level, and are among the most vulnerable, facing limited access to reliable and affordable health care.

Planned Parenthood Federation of America strongly opposes the "No Taxpayer Funding for Abortion Act H.R. 7", a misleadingly named piece of legislation that represents a dangerous assault on women's health and a harmful attempt to take away the comprehensive private health insurance coverage that millions of women have today. The ultimate goal of this legislation is to restrict women's access to safe and legal abortion by fundamentally altering the health insurance market from a market where abortion coverage is the industry standard to one where insurance coverage for abortion is eliminated. Instead of pursuing additional barriers for women seeking safe and legal abortion, we urge Congress to shift focus towards measures that expand women's access to comprehensive health care.

If enacted, H.R. 7 would threaten the availability of abortion coverage in the entire private insurance market. Today, absent state law, health plans participating in the Marketplace may determine for themselves whether or not to offer coverage of abortion, as well as a wide array of other health services beyond the essential requirements. However, this bill will effectively ban abortion coverage in the new health insurance Marketplace by prohibiting individuals who buy insurance coverage in the Marketplace from using their own private funds, supplemented by a federal subsidy, to purchase a plan that covers abortion beyond the narrow, dire circumstances of life-endangerment, rape, and incest. At a time when the Affordable Care Act is expanding coverage to millions of Americans, Congress should not jeopardize the health of women. Health insurance industry experts have repeatedly stated that this type of restriction could result in private health insurance companies dropping abortion coverage altogether, leaving millions of women— many of whom never thought they might need an abortion— without coverage.[1] Furthermore, federal law already requires that insurance plans withhold federal subsidies from going toward abortion services in a Marketplace plan. Under the ACA, health plans are required to allocate a portion of the consumer's premium (funded entirely with private funds) toward covering abortion.

In addition, H.R. 7 is more than a simple restatement of objectionable existing law, such as the Hyde amendment, which withholds federal funding from abortion except in the case of rape, incest, or other federal prohibitions. Through various amendments, federal law withholds federal dollars from covering a

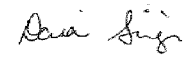
woman's abortion. As a result, millions of women who rely on public health insurance, such as Medicaid and the Federal Employees Health Benefit Program, are unable to access comprehensive reproductive health coverage, even if they face severe danger to their health. Current law also prohibits the District of Columbia from using local funds for abortion-related services. This bill would make all these unfair, harmful restrictions permanent.

This bill is dangerous to women's health because it would deny millions of women the coverage she needs – even when her health is at risk. A woman's health insurance should enable her to take care of her health and well-being. Decisions about whether to choose adoption end a pregnancy, or raise a child must be left to a woman, with the counsel of her family, her faith, and her doctor or health care provider. The bill will also deny access to abortion by banning abortion as part of any health care service furnished in a health care facility owned or operated by the federal government or by any employee of the federal government.

H.R. 7 takes away important tax benefits for American families and small businesses across the country solely because the health insurance they choose includes coverage of abortion. Under the bill, individuals who choose to enroll in health insurance that includes abortion will not be able to receive federal subsidies to help pay for the cost of their health care. In addition, small businesses that offer their employees comprehensive health insurance coverage that includes abortion will no longer be able to claim existing deductions or claim the Small Business Health Tax Credit – placing an unworkable burden on a key driver of the American economy. Denying these important tax benefits to families and small businesses solely because of the insurance they choose is a drastic and far-reaching move, especially because the majority of private employer-based health plans and health plans in the private insurance market cover abortion. The bill also prohibits a woman from using her privately-funded, tax-preferred account, such as a flexible spending account or health savings account, for any costs associated with an abortion. This is a departure from current tax treatment of medical expenses and insurance coverage, and yet another attempt by politicians to interfere in a woman's personal decision-making and undermine women's access to health care.

A recent 2013 nationwide poll conducted by Hart Research Associations on behalf of Planned Parenthood Federation of America showed that a strong majority of voters – Republicans (62 percent), Democrats (78 percent), and Independents (71 percent) – say these issues are the wrong issues for Congress and their state legislatures to spend time on. Instead of focusing on important issues like jobs and the economy, sponsors of this bill are trying to unfairly single out abortion at a time when the country has urgent problems to deal with. The United States continues to have some of the highest rates of teen pregnancy and maternal and infant mortality rates in the developed world. There are significant gains to be made in increasing women's access to comprehensive health care. H.R. 7 does nothing to address these needs, and instead creates additional obstacles for women, often in vulnerable situations, who are seeking safe and legal health care. We strongly urge Congress reject H.R. 7 and instead increase access to preventive health services and protect women's access to safe and legal abortion.

Sincerely,



Dana Singiser
Vice President of Public Policy and Government Relations
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[1] Rosenbaum, Sara, et. al, "Testimony before the House Energy & Commerce Committee." February 9, 2011.

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Testimony of Nancy Stanwood, MD, MPH
Board Chair, Physicians for Reproductive Health
Submitted to the House Judiciary Committee
Subcommittee on the Constitution and Civil Justice
January 9, 2014

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. A large number of the doctors Physicians represents practice in the field of obstetrics and gynecology, but many are pediatricians, fertility doctors, family physicians, cardiologists, neurologists, radiologists, and others. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

Physicians welcomes the opportunity to submit testimony on H.R. 7, misleadingly named the "No Taxpayer Funding for Abortion Act." This dangerous bill would effectively ban insurance coverage for abortion, even to protect a woman's health. This could put access to abortion out or reach for countless women. A woman's health insurance should meet all her health needs and cover a full range of medical procedures, including abortion.

H.R. 7 would decimate private insurance coverage for abortion by raising taxes on individuals and businesses to discourage coverage. H.R. 7 also codifies harmful riders that already deny scores of underserved women insurance coverage for abortion. If enacted, millions more women could be deprived of coverage for abortion. Moreover, H.R. 7 contains very limited exceptions that are inadequate to protect a woman's health. This bill ignores the very real situations women face and, if enacted, would have a devastating impact on their ability to access safe and legal abortion care.

Every day my colleagues and I treat women who are able to use their insurance to obtain needed medical care. Sadly, we also see patients without the financial resources to pay for an abortion. For a woman to be able to make a real decision based on what's best for her and her family, she needs to be able to afford her care.

In my practice, I had a patient, Carol[1], who was excited to give birth to her first child. Her husband, a Marine, was serving in Afghanistan. They received health insurance through the military. Sadly, in Carol's second trimester, she learned that her baby had anencephaly; it would be born without a brain. After much deliberation, she and her husband decided to terminate the pregnancy. They were shocked to learn that their health insurance would not cover the abortion and would only cover a situation in which Carol's life was in danger.[2] Her husband was outraged, telling me, "I'm over there defending my country, and they won't even take care of my family?" The law treated this family terribly during a time of great stress and need. Under H.R. 7, other families would be forced to repeat Carol's painful experience.

I remember Melissa, the youngest in a large tight-knit family and a high school Reserve Officers' Training Corps (ROTC) graduate, who was 19 years old when she went to enlist in the Marines. The intake testing revealed that she was pregnant. She had been careful to use condoms with her boyfriend, but the condoms had failed. Melissa was clear about her plans for the future, which included starting a family once her military career was well established. She and her mother were fortunate not to have to worry about insurance coverage for her care, as their private insurance covered the procedure. This allowed Melissa to pursue her dreams and serve our country.

Dr. Douglas Laube of Madison, Wisconsin, immediate past board chair of Physicians, had a patient, Beth, who was pregnant with her first child and looking forward to becoming a mother. Three months into her pregnancy, she developed dangerously high blood pressure. Without an abortion, Beth might have suffered a stroke or kidney damage. She made the decision to end her pregnancy. Beth's medical condition is just one of many that can complicate pregnancy. But H.R. 7 would leave women like Beth without insurance coverage for abortions necessary to protect their health.

Physicians consulting medical director Dr. Anne Davis of New York cared for a patient named Liza, who had insurance through her low-wage job at a hospital. Liza was married with two children, and became pregnant while taking the pill. Although it was an unintended pregnancy, Liza and her husband wanted to have the baby. But then Liza's husband lost both of his jobs. They decided to have an abortion. Because of complicated health circumstances, Liza's abortion cost $10,000—an amount that would have destroyed her family's already strained finances if they had been required to pay out of pocket. Fortunately, her insurance covered the procedure.

Physicians Leadership Training Academy Fellow Dr. Kristina Tocce of Denver treated a patient with a complicated pregnancy. An ultrasound showed that her patient Consuela's fetus was not developing kidneys. Most infants with this problem do not live more than a few hours. Also, Consuela's placenta was covering the opening of her cervix. This condition, if left untreated, can result in life-threatening bleeding during delivery and requires a cesarean section. Conseula and her husband wanted to terminate the pregnancy, but her insurance was through Medicaid. Because Consuela's medical condition did not endanger her life, she did not qualify for abortion coverage under Medicaid's life exception. Out of pocket, her abortion would have cost more than $4,000, an impossible sum. Consuela continued to carry her pregnancy and suffered tremendous emotional turmoil. Six weeks later, her fetus died in utero. The legislation under consideration would force women all over the country into situations like Consuela's.

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[1] Please note that all patient names are changed to protect confidentiality.

[2] In 2012, federal law was changed to allow coverage in instances of rape and incest.

In Seattle, Dr. Deborah Oyer saw a patient, Allison, a 34-year-old mother of three with an unintended pregnancy. She was still deciding whether to continue her pregnancy when she learned her youngest child had leukemia. She and her husband quickly realized that they could not have another child at that time. Allison needed to take leave from work and stay at the hospital with their daughter for medical treatments. Her husband needed to stay at home, two hours away from the hospital, to work and care for their two other children. Fortunately, Washington State Medicaid covered her abortion. But Allison and her family would have faced great hardship if they had had to pay out of pocket. Access to affordable insurance that covers abortion is essential for women and their families.

For these real women and their families, the decision to have an abortion was made after consultation with their health care providers and consideration of all the issues involved. Abortion was a critical medical procedure that protected their health as well as the well-being of their families. H.R. 7 threatens millions of American women by trying to make insurance coverage for abortion impossible to obtain. Health insurance should take care of women; not abandon them. If H.R. 7 were passed, real women like Beth, Melissa, Liza, Consuela, Allison, and Carol would suffer as a result. It is critical to the lives and health of American women that this bill be defeated. Please vote against H.R. 7.

The Advocate of South Carolina Small Business
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January 14, 2014

The Honorable Robert Goodlatte,
Chairman
Committee on the Judiciary
2138 Rayburn House Office Building
Washington, DC 20515

The Honorable Trent Franks, Chairman
Subcommittee on Constitution and Civil Justice
2138 Rayburn House Office Building
Washington, DC 20515

The Honorable John Conyers, Ranking Member
Committee on the Judiciary
B351 Rayburn House Office Building
Washington, DC 20515

The Honorable Jerry Nadler, Ranking Member
Subcommittee on Constitution and Civil Justice
B351 Rayburn House Office Building
Washington, DC 20515

Re: H.R.7

Dear Chairman Goodlatte, Chairman Franks, Ranking Member Conyers and Ranking Member Nadler,

After decades of escalating group health insurance premiums and demands for Congressional action for relief, our smallest of businesses finally were given the opportunity for federal health insurance tax credits through the Affordable Care Act. Now H.R 7 threatens to erase this benefit for small businesses because it would eliminate the health insurance tax credits for any existing or new plans that provide coverage for abortion.

The problems H.R. 7 would cause for small businesses that are trying to do the right thing and offer health insurance have nothing to do with the ideological intent of this bill. Even if a small business owner were to agree with the intent, the cost in time, money and continuity of policy is very significant.

1. Small business owners do not have the expertise to closely examine healthcare plans to determine if abortion coverage is included. Such services are not labeled "abortion" but rather fall into numerous clauses in a health care policy from prescription drugs to outpatient surgery to maternity care that includes unforeseen

complications. Small business owners are no more prepared to completely understand the fine print of their health insurance policies than are members of Congress.

2. Requiring a small business owner to try to understand the intricacies of their health insurance policies would require considerable time on their own or with an insurance agent (who also probably has no idea how to interpret the verbiage in the policy as it relates to abortion). Essentially H.R. 7 will cause a small employer to divert time from running the business. And if time is money, as we are all told, then H.R. 7 will be an increase in cost for small businesses offering health insurance.

3. Small businesses that finally determine that their health insurance policy does in fact cover even one abortion service will be financially punished in one of two ways. Either they can keep their present policy and lose thousands of dollars in hard won tax credits or they will give up their current health plan and most likely have to pay higher premiums for a new plan.

H.R. 7 is simply a slap in the face to the millions of small businesses now offering health insurance to employees and eligible for the new tax credits. Targeting small businesses for such punitive action, while ignoring big businesses that also receive tax benefits when offering health insurance, demonstrates a callous disregard for the "backbone of our economy," as members of Congress love to proclaim about small businesses.

Sincerely,

Frank Knapp, Jr.
President & CEO

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

TESTIMONY OF JUDY WAXMAN, VICE PRESIDENT FOR HEALTH AND REPRODUCTIVE RIGHTS
NATIONAL WOMEN'S LAW CENTER

BEFORE THE SUBCOMMITTEE ON THE CONSTITUTION AND CIVIL JUSTICE OF THE HOUSE COMMITTEE ON THE JUDICIARY

HEARING ON H.R. 7

January 9, 2014

Mr. Chairman, members of the Committee, I am Judy Waxman, Vice President of Health and Reproductive Rights at the National Women's Law Center (NWLC). Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families, including to protect and advance women's reproductive health and rights. Thank you for the opportunity to submit testimony on H.R. 7.

H.R. 7 is a dangerous and misleading bill that imposes a devastating tax increase on some families and small businesses that want comprehensive insurance plans that include coverage of abortion. Though the bill's supporters argue that it "merely codifies" federal law—which itself is already highly restrictive—such claims are false. H.R. 7 will increase specific taxes and costs in order to prevent women from obtaining abortion care and will eliminate abortion coverage for millions of women.

This bill twists the tax code into a tool to take abortion coverage away from women. By imposing tax increases on women and small businesses that purchase insurance plans that cover abortion, H.R. 7 will likely force them to drop the abortion coverage from their otherwise comprehensive plans, with potentially devastating results for women and their families.

H.R. 7 could render millions of individuals and small businesses ineligible for a wide range of tax credits and deductions simply because their insurance plans include coverage of abortion. For example, H.R. 7 could make millions of small businesses ineligible for the Small Business Health Tax Credit, which is worth up to 50 percent.[i] Currently, a small business can choose a health insurance plan for its employees, and the employer and employees each make contributions to pay the premium out of their private dollars. At the end of the year, the employer can claim the Small Business Health Tax Credit,

which refunds a portion of the employer's contributions. Under H.R. 7, the employer would not be eligible for the tax credit if the plan included coverage of abortion—even though the premiums were paid entirely by the employer and employee with their own, private dollars. If H.R. 7 results in the elimination of private insurance coverage of abortion altogether, it would go even further in restricting what individuals can purchase with their own, private dollars, preventing anyone from being able to purchase inclusive coverage—even if they receive no tax-preferred treatment at all.

H.R. 7 will also make millions of individuals otherwise eligible for the premium assistance available under the Affordable Care Act ineligible if their insurance plans include coverage of abortion. Under current law, certain individuals are eligible for Premium Tax Credits to help pay for health insurance.[ii] H.R. 7 makes any insurance plan that includes coverage of abortion ineligible for Premium Tax Credits. This is true even though the Affordable Care Act already includes substantial rules to ensure that no federal funds are used to pay for abortion coverage.

H.R. 7 would impose income taxes on money in tax preferred savings accounts, such as a flexible spending or a health savings account, if it is used to pay for abortion care. Under current law, individuals and employers can contribute to these accounts a portion of their wages, which are exempt from taxation so that such funds will be available for medical needs.[iii] Under H.R. 7, a woman who uses funds from a flexible spending or health savings account to pay for an abortion must pay income tax on the funds she uses to cover the procedure.

H.R. 7 would also raise taxes on a woman who spends a large percentage of her income on health needs if part of her needed health care is abortion care. Currently, medical expenses that exceed 7.5% of a taxpayer's gross income are deductible.[iv] Under H.R. 7 a woman with serious medical complications requiring an abortion that cost tens of thousands of dollars would not be able to deduct the cost of her abortion. She would have to pay higher income taxes than a person with a similarly serious and expensive medical problem because her treatment required that her pregnancy be terminated.

By substantially raising taxes and costs on millions of individuals and employers, H.R. 7 could force not only those individuals and employers to drop abortion from their health insurance plans, but would close down the entire private insurance market coverage of abortion. H.R. 7 prohibits health plans that include coverage of abortion from receiving a range of tax credits. Private insurers are therefore incentivized to exclude coverage of all abortions in order to ensure that they will be able to accept customers who receive federal subsidies.[v] Similarly, H.R. 7 pushes individuals and small businesses to switch to plans that do not cover abortion by only offering tax-favored treatment to plans that exclude such coverage. This distorts the private market by driving customers away from plans that include abortion coverage, which would likely result in plans dropping abortion coverage. Some have argued that H.R. 7 and related legislation could result in the entire private market dropping abortion coverage, eliminating abortion coverage from the private insurance market altogether and making such coverage unavailable to anyone.[vi]

H.R. 7 does not even make any exceptions for abortions that are necessary to save a woman's health. Under H.R. 7, women would be left without coverage for pregnancy termination necessitated by medical complications, which can cost thousands of dollars. Under a hypothetical example, which could be all too true, a pregnant woman who is diagnosed with a serious and rapidly spreading cancer could be in grave danger if she does not terminate her pregnancy so she can immediately begin chemotherapy and radiation treatment. Unfortunately, because of her current health status, the abortion procedure she needs to protect her health and possibly her life is expensive. Because of H.R. 7's limitations on tax credits, she would be forced to drop the inclusive policy she had for years, which included abortion coverage. So, if H.R. 7 passed, her health insurance policy would not cover abortion. Nor would it allow her to use monies she had put into a flexible spending account to help her cover unexpected health expenses without paying additional taxes, even if her pregnancy termination cost a substantial portion of her salary that year. Such barriers could force the woman into bankruptcy or remain pregnant at great risk.

Even the bill's narrow exemption can hurt the very women it seeks to protect from H.R. 7's onerous provisions. Under the exception, women who were raped can include the costs of the abortion as a deduction for high medical expenses and can pay for the abortion with funds from a tax-preferred account. However, a woman doing so would have to demonstrate to the IRS that she was raped and subsequently had an abortion. During a hearing on this legislation in the 112th Congress, the Joint Committee on Taxation testified that this was indeed the case as the burden of proof would be on the taxpayer.[vii]

In addition to twisting the tax code to deny women comprehensive health insurance, H.R. 7 further harms women by making certain restrictions on abortion coverage permanent. Currently, federal restrictions on abortion coverage require renewal every year as they are imposed through the appropriations process. H.R. 7 makes these restrictions permanent law. Thus, women covered under Medicaid, women serving in the U.S. military, federal employees, residents of the District of Columbia, women in federal prisons, and women covered by the Indian Health Service would permanently be denied health insurance that includes abortion coverage except for very narrow circumstances. These harmful restrictions endanger women's health and place particular burdens on low-income women.

Finally, offending the principles underlying D.C. home rule, H.R. 7 permanently prohibits the District of Columbia from using locally raised funds to offer abortion care for women who otherwise could not afford it. If H.R. 7 were to become law, anti-choice members of Congress would strip the District of Columbia of the power that all 50 states currently have: the power to make decisions about how to spend locally-raised revenue.

The government has used economic coercion to prevent women who depend on the government for health insurance from getting abortions for over 30 years. Now this harmful policy is being vastly expanded by using the tax code to prevent millions of additional women from obtaining health insurance that covers abortion. The National Women's Law Center urges the Committee to reject this dangerous and misleading bill.

[i] I.R.C. § 45R (2010).
[ii] I.R.C. § 36B (2010).
[iii] I.R.C. § 106 (2011).
[iv] I.R.C. § 213 (2010).
[v] *See No Taxpayer Funding for Abortion Act: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 112th Cong. (2011) (testimony of Sara Rosenbaum, Chair, Dept. of Health Pol'y, George Washington Univ. Sch. Pub. Health and Health Servs.).
[vi] *See generally* id.
[vii] *See No Taxpayer Funding for Abortion Act: Hearing Before the Subcomm. on Select Revenue Measures of the. Comm. on Ways and Means*, 112th Cong. (2011) (testimony of Tom Barthold, Chief of Staff of the Joint Committee on Taxation.).

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